**HEALTH AND SENIOR SERVICES**

**DIVISION OF LOCAL HEALTH AND EMERGENCY SERVICES**
**Public Health Practice Standards of Performance for Local Boards of Health in New Jersey**

**Adopted New Rules: N.J.A.C. 8:52**
Proposed: January 7, 2002 at 34 NJR 241(a)
Adopted: December 30, 2002 by Clifton R. Lacy, M.D., Commissioner, Department of Health and Senior Services and the Public Health Council, Miriam Cohen, Chair

Filed: December 30, 2002 as R. 2003d.51, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).
Authority: N.J.S.A. 26-1A-15 and 26:3A2-1 et seq.

Effective Date: February 18, 2003

Expiration Date: February 18, 2008

On January 7, 2002, the New Jersey Department of Health and Senior Services proposed new rules governing local boards of health which consist of 16 subchapters found at N.J.A.C. 8:52. These rules were proposed to replace the Minimum Standards for Local Boards of Health in New Jersey that had not been substantially changed since 1986. Additionally, notice of proposal was sent to numerous interested parties, including, but not limited to, local health departments, public health organizations, the professional organizations representing health officers, local boards of health, municipalities, and other affected State Departments. The proposal was placed on the Department's website and a copy forwarded to the news media maintaining an office at the State House Complex. A public hearing was held before the Public Health Council on February 4, 2002 in Trenton. The hearing record may be reviewed by contacting Ajhezza Gonzalez, Department of Health and Senior Services, PO Box 360, Trenton, NJ 08625-0360. N.J.A.C. 8:52 expired on December 10, 2001 pursuant to Executive Order No. 66 (1978). Prior to that date, a notice of proposed new rules was filed with the Office of Administrative Law and was published as a notice of proposal in the January 7, 2002 New Jersey Register (See 34 NJR 241). In accordance with N.J.A.C. 1:30-6.4 (f), the expired rules are adopted herein as new rules.

**Summary** of Public Comments and Agency Responses:

The Department received 335 comments from a total of 133 commenters. Thirty-two verbal comments, with 25 of them provided in writing, were presented at the public hearing. An additional 73 written comments were received by the February 6, 2002 deadline. Seven written comments were received after the deadline. To date, an additional 21 resolutions from local boards of health and municipal governing bodies have been received. Each commenter has been assigned a number for identification

purposes. These numbers appear in the comments as a method of identifying commenters.

Forty-two commenters simply expressed support for the rule or one of the requirements. These have been addressed under the category of positive support. All other comments addressing concerns, technical issues and varying degrees of opposition are addressed in sections II. through XIII. below. One hundred thirty-seven comments were on specific sections of the rule (technical). Of these, the Department has disposed of 79 comments and accepted and made technical changes in response to 28. The remaining 30 comments suggest or recommend substantive changes which can not be made upon adoption. The Department will consider future amendments to the rule as suggested by the commenters. Comments encompassing similar themes and concerns have been organized and will be addressed as follows:

I. Support;
II. Process;
III. Existing Minimum Standards
IV. Cost/Funding;
V. State Mandate/State Pay;
VI. Other Support;
VII. Enforcement Issues;
VIII. Competing Commitments;
IX. Jurisdiction Change;
X. Legal Authority;
XI. Outside the Authority of N.J.A.C. 26-8:52;
XII. Resolutions from Local Boards of Health; and
XIII. Comments on Specific Sections of the Rules.

Testimony alone (see asterisk) and testimony supplemented by written comments presented at the February 4, 2002 public hearing were provided by:

Andrea Aughenbaugh, RN, CS, CAE, Chief Executive Officer and Carolyn Torre, RN, MA, APN, C, Director of Practice, New Jersey State Nurses Association (Commenter 1); Frances Ward, Ph. D., RN, APN, C, Professor and Dean, University of Medicine and Dentistry of New Jersey, School of Nursing (Commenter 2); Violet Cherry, Health Officer, City of Englewood, representing Lou Apa, Health Officer, Closter, Rockleigh, Dan Levy, Health Officer, Washington Township, Cresskill, Demarest, River Vale, Harrington Park and Emerson, Rod Preiss, Health Officer, Hillsdale, Midland Park, Montvale, Northvale, Old Tappan, Upper Saddle River, Waldwick, andWyckoff, Debra Ricci, Health Officer, Elmwood Park, and Ridgefield Park, Steve Wielkocz, Health Officer, Fort Lee, and Jad Mihalinec, Health Officer, Palisades Park, Ridgefield), (Commenter 3); Bojana Beric, MD, MA, President NJ SOPHE (Commenter 4); Earl A. Marsan, President of the City of Englewood Board of Health (Commenter 5); Mitchell L. Rosenberg, City Council President, City of Englewood (Commenter 6); Paul D. Roman, Vice President, New Jersey Local Boards of Health and President , Monmouth County Regional Health Commission (Commenter 7);Albert Greco, MA, Health Officer/

Director Human Services, City of Clifton (Commenter 8); Herb Roeschke, Health Officer, Cumberland/ Salem Health Department * (Commenter 9); John Beckley, Health Officer, County of Hunterdon (Commenter 10); Sue Lachenmayr, MPH, CHES, independent health educator consultant in New Jersey and President-elect, National Society for Public Health Education (Commenter 11); Fern Walter Goodhart, MSPH, CHES, Director of Health Education, Rutgers and Borough Councilwoman and liason to Board of Health, Highland Park (Commenter 12); Sylvia Bookbinder, Certified Health Education Specialist, licensed New Jersey Health Officer and past president of the New Jersey Public Health Association (Commenter 13); Kim Zagorski, President Elect, New Jersey Environmental Health Association (Commenter 14); James Norgalis, Health Officer, Branchburg Township Health Department * (Commenter 15); David Richardson, Health Officer, Manalapan Township* (Commenter 16); Margaret Dyer-Weissman, RN, MSN, Immediate Past President, New Jersey Association of Public Health Nurse Administrators, Inc., (Commenter 17); Sindy M. Paul, MD, MPH, President, New Jersey Public Health Association (Commenter 18); Clem Ferdinando, President-Elect, New Jersey Public Health Association* (Commenter 19); Robert Gogats, Public Health Coordinator, Burlington County* (Commenter 20); Mark Guarino, Health Officer, Bergen County Department of Health Services and New Jersey County Health Officers Association (Commenter 21); Tracye McArdle, Health Officer Atlantic County Department of Health (Commenter 22); Peter Correale, President, New Jersey Health Officers Association (Commenter 23); Pat Pignatelli, Health Officer, Borough of Lincoln Park* (Commenter 24); Nancy Moore-Caira, MPH, CHES, New Jersey Society for Public Education (Commenter 25); Joan Collins, MPH, CHES, Health Educator, Bergen County Department of Health Services (Commenter 26); Leonard Fiorenza, MPH, Bergen County Department of Health Services (Commenter 27); David Henry, Health Officer, Montgomery Township Health Department (Commenter 28); Suzanne Rose, MS, Health Educator (Commenter 29); Patricia A. Hart, Retired Health Officer (Commenter 30); Karen Denard Goldman, Ph.D., CHES, Health Education and Social Marketing Consultant (Commenter 31); and Bill Hinskillwood, Health Officer, Princeton Regional Health Commission* (Commenter 32),

**Written comments were provided by:**

Margaret Dyer-Weissman, RN, MSN, Director of Public Health Nursing Service, Sussex County Health Department (Commenter 33); Marianne McEvoy, MPA, RN, Director Public Health Nursing, County of Hunterdon (Commenter 34); Peg Shoemaker, RN, BSN, New Jersey Association of Public Health Nurse Administrators, Inc., (Commenter 35); Dorothy Harth, RN, BSN, County Division Head, Warren County Health Department, Public Health Nursing Agency (Commenter 36); Sandra S. Van Sant, RN, MN (Commenter 37); Jacquilaine Meehan, RN, President, Greater Valley Public Health Nurses Association (Commenter 38); Donna K. Sponseller, RN, MS, New Jersey Association of Public Health Nurse Administrators (Commenter 39); Catherine Lewis, MPH, CHES (Commenter 40); Lucille Y-Talbot, MPA, Lifestyle Training Consulting Services, Inc. (Commenter 41); Rebecca Selenko, MS, CHES, Health Educator (Commenter 42); Marla Klein, CHES, Oradell (Commenter 43); Concetta Capornno, Assistant Health Educator (Commenter 44); Amy Lewis, BS, CHES, Health

Educator/Municipal Alliance Coordinator, Bernards Township Municipal Alliance (Commenter 45); Monique C. Davis, MPH, CHES, Health Education Consultant, Town of Harrison, Department of Health (Commenter 46); Marjorie E. Doremus, Ph.D., RD, Coordinator, Health Promotion Resource Center, Paramus (Commenter 47); Anne Hewitt, Ph.D., CHES, Director, MHA Program, Assistant Professor, Graduate Programs in Public and Healthcare Administration, Seton Hall University (Commenter 48); Angela R. Musella, MA, CHES, Assistant Health Officer, Montclair (Commenter 49); Joanna Hayden, RN, Ph.D., CHES, Chairperson, Department of Community Health, William Paterson University (Commenter 50); Christine B. Shesler, MS, CHES, Madison (Commenter 51); Phyllis M. Kumpf, RN, Med., CHES, Director of Community Health, Somerset Medical Center (Commenter 52); Karen Denard Goldman, PhD, CHES, President and M. Elaine Auld, MPH, CHES, Executive Director, Society for Public Health Education, Washington, D.C. (Commenter 53); Kelly Bishop Alley, CHES, Acting Executive Director, Chair, Board of Commissioners, National Commission for Health Education Credentialing, Inc., (Commenter 54); Parvin A. Khanlou, Ph.D., CHES (Commenter 55); Suzanne Hooper, Registered Environmental Health Specialist and Health Educator, Trenton (Commenter 56); William G. Dressel, Jr., Executive Director, New Jersey State League of Municipalities (Commenter 57); Lynn Waishwell, Ph.D., CHES, Director and Louise Weidner, Ph.D., Assistant Professor, Health Education and Behavioral Science Division, School of Public Health, UMDNJ (Commenter 58); Deborah Pinto, Chief, Office of Local Environmental Management, Department of Environmental Protection (Commenter 59); Sue Gamrin, Resident of Englewood (Commenter 60); Richard N. Pierson, Jr., M.D. FACP, President, Friends of Englewood Health Department (Commenter 61); Constance Alston, Vice-President, Friends of the Englewood Health Department, Community Activist (Commenter 62); Samuel Slipp, MD & Sandra Slipp, Ph.D. (Commenter 63); Shirley Hall Green, Englewood Resident (retired High School Teacher) (Commenter 64); Herb & Frances Honig, Residents of Englewood (Commenter 65); Julian and Adelaide Bash, Residents of Englewood (Commenter 66); Karen Ring, President, Bergen County Health Officers' Society(Commenter 67); Marguerite L. Pilsbury, Secretary, The Borough of Demarest, Board of Health (Commenter 68); Deborah Ricci, MPA, Health Officer, Department of Health, Borough of Elmwood Park (Commenter 69); George D. Fosdick, Mayor, Village of Ridgefield Park (Commenter 70); Bernadette A. Reilly, Secretary, Board of Health, on behalf of Rudolph C. Dangelmajer, MD, President, Berkeley Heights Board of Health (Commenter 71); Josephine A. Mann, Secretary to Board of Health, on behalf of David M. Schreck, MD, President, Summit Board of Health (Commenter 72); Rod W. Preiss, Health Officer, Board of Health, Borough of Hillside (Commenter 73); Dolores Camlet, Borough Clerk, on behalf of the Mayor and Council of the Borough of Elmwood Park (Commenter 74); Gene S. Osias, MSW, Health Director, Township of Vernon (Commenter 75); Rod W. Preiss, Health Officer, Northwest Bergen Regional Health Commission (Commenter 76); Kenneth R. Hawkswell, Health Officer, Department of Health, Township of West Milford (Commenter 77); Carl Seber, Health Officer, Borough of Hopatcong (Commenter 78); Jeffrey Trifari, Councilman, Borough of Ridgefield (Commenter 79); Robert D.Roe, Health Officer, Maplewood Township (Commenter 80); Sandy Farber, Mayor, Borough of Palisades Park (Commenter 81); George Sartorio, Assistant Health Officer, Department of Health, Vineland (Commenter

82); Valerie Vainieri Huttle, Bergen County Freeholder and resident of Englewood (Commenter 83); Henry G. McCafferty, Health Officer, Division of Health, Department of Human Resources, City of Passaic (Commenter 84); Andrew C. Simpr, Jr. Health Officer, Township of Piscataway (Commenter 85); David Volpe, Health Officer, Department of Health, Borough of Bergenfield (Commenter 86); John A. W. Richardson, Mayor, Township of Fredon (Commenter 87); Philip H. Morlock, Health Director/Health Officer, Sussex County (Commenter 88); John O. Grun, M.S., Director of Health and Human Resources, Edison (Commenter 89); Daniel Levy, Health Officer, Local Health Agency, Township of Washington (Commenter 90); Mercer County Health Officers Association (Commenter 91); Timothy J. Hilferty, Director, Long Beach Island Health Department (Commenter 92); Patricia Hegadorn, Registered Nurse, licensed Health Officer and former President of the New Jersey Health Officers' Association, Paramus (Commenter 93); Kevin G. Sumner, Health Officer, Middle-Brook Regional Health Commission (Commenter 94); Denise A. DePalma Farr, MA, CHES, Health Officer/Director, Fair Lawn Health Department (Commenter 95); JoanValas, MS, APRN, BC, Public Health Task Force/Executive Committee Co-Chair, Past President New Jersey Local Boards of Health Association, President Park Ridge Board of Health (Commenter 96); Lucy A. Forgione, MS, CHES, Health Officer, Director of Health, Bernards Township Health Department (Commenter 97); Joseph J. Przywara, Public Health Coordinator, Ocean County Board of Health (Commenter 98); Carol Wagner, Health Officer, Mid-Bergen Regional Health Commission (Commenter 99); John G. Christ, Health Officer, City of Hackensack (Commenter 100); Wayne A. Fisher, MA, Township Health Officer, Township of Teaneck (Commenter 101); Flo Rice, Ed.D., RN, Borough of Madison (Commenter 102); Dana Ann O'Connor, RN, BSN, Public Health Nurse Supervisor of Long Beach Island Health Department and President of New Jersey Association of Public Health Nurse Administrators, Inc., (Commenter 103); Chuck O'Donnell, Chief, New Jersey Immunization Program, Department of Health and Senior Services (Commenter 104); and Judith Hall, MS, RN, CS, Public Health Consultant, Nursing, Family Health Services, Child Health (Commenter 105).

**Comments Received After February 6, 2002**

Nancy M. Caira, MPH, CHES, Chair, Practice Standards Review Committee, NJ SOPHE (Commenter 106); Joseph S. Rompala, Township Administrator, Township of Montville (Commenter 107); Stephen S. Wielkocz, Health Officer, Department of Health, Borough of Fort Lee (Commenter 108); Ellen M. Capwell, Ph.D., CHES, Coordinator, Coalition of National Health Education Organizations (Commenter 109); Sandra Ottenberg, RNc, BSN, MPH, CHES, (Commenter 110); and Jenna Sheinfeld, MPH, CHES (Commenter 111).

**Resolutions Received from the following entities:**

Lenore Schiaclh, City Clerk, City of Englewood, Bergen County (Commenter 112); Vincent R. Farias, President, New Jersey Association of Counties (Commenter 113); Joanne Charner, Acting Municipal Clerk, Township of Fredon, Sussex County (Commenter 114); John Hopper, Secretary, Paramus Board of Health, Borough of Paramus, Bergen County (Commenter 115); Jan Manus, Secretary, Board of Health, Borough of Allendale, Bergen County (Commenter 116); Doris L. Dukes, City Clerk,

City of Hackensack, Bergen County (Commenter 117); Carol Ann Hahn, Secretary, Board of Health, Frankford Township, Sussex County (Commenter 118); Louanne Cular, RMC/CMC, Municipal Clerk, Frankford Township Committee, Sussex County (Commenter 119); Elaine A. Morgan, Clerk of the Board, Sussex County Board of Health, Sussex County (Commenter 120); Doreen Klinger, Borough Clerk, Borough of Hamburg, Sussex County (Commenter 121); Richard H. Hodson, Mayor Borough of Hopatcong, Sussex County (Commenter 122); Barbara Harabes, Board of Health Secretary, Hampton Township, Sussex County (Commenter 123); Eileen Klose, RMC, Township Clerk Administrator, Township of Hampton, Sussex County (Commenter 124); Ruth Rhodes, Chairperson, Valerie Cannata, Secretary, Byram Township Board of Health, Sussex County (Commenter 125); Jane Bakalarczyk, RMC, Municipal Clerk, Hardyston Township Council, Sussex County (Commenter 126); David L. Hughes, City Clerk, City of Summit, Union County (Commenter 127); Gary Fanning, Board President and Elaine Lubowiecki, Board Secretary, North Arlington Board of Health, Bergen County (Commenter 128); Karin Kennedy Dubowick, Secretary, Board of Health, Oakland, Bergen County (Commenter 129); Geraldine Hallissey, Secretary, Mahwah Board of Health, Bergen County (Commenter 130); Linda Canavan, Secretary, Saddle River Board of Health, Bergen County (Commenter 131); Jackie Huelbig, Secretary, Andover Township Board of Health, Sussex County (Commenter 132); and Claire M. Hern, Beverly City Board of Health, Burlington County (Commenter 133).

**I. Support**

COMMENT: Fourteen commenters provided general praise for the rule. (1, 2, 9, 10, 11, 12, 13, 18, 19, 20, 21, 22, 31 and 93.) Of these, five represented associations of public health professionals (New Jersey Health Officers Association, New Jersey Association of County Health Officers, New Jersey Public Health Association, New Jersey Society for Public Health Education, Inc., and the New Jersey State Nurses Association.) One commenter stated, … "Today I appear before you to praise these standards, not to bury them. These standards represent over five years of hard work by state and local staff. These represent our best effort to create a road map for a network of effective and efficient public health activities. … I believe it is crucial that this action take place now rather than later. There will be those that have come here today to bury these standards and retain our current system. … I urge you to enact these standards without any modifications. I am sure that if we find at some later date some fine tuning is necessary, we can all get back together again, and make those minor modifications, but I believe that to wait any longer will only worsen the problem, and I don't think that we can ever come to 100 percent agreement on all issues." (9) Another commenter stated, "… The public is more aware of the threat of global disease reaching our shores and fearful of biological terrorism. Currently, public health in New Jersey is neither organized nor practiced to meet this extremely important responsibility. Both at the state and local level, there is a limited public health infrastructure and virtually no systemic practice. … the state and local health departments, the New Jersey Public Health Council and non-government health care/ stakeholders have convened to review, develop, and recommend an improved statewide public health system. … This effort has left no stone unturned in referencing the best thinking and models from across the nation. It has become apparent that ideal

public health protection will be realized only when there is a systematically linked national, state and local public health system. …" (21) One other commenter stated, "I applaud the Department and the Public Health Council for recognizing the urgent need to take action in restructuring our system – and for drawing upon the very best thinking at the national level. The '10 essential' public health services will take on a new meaning in the State of New Jersey and our residents will benefit accordingly. There are always some who will be threatened or made uneasy by change. But in the end, I believe the new standards will work for all and we will look back at this time as a landmark moment when we did the right thing for the right reasons." (10) One commenter stated, " … We behave as though every municipality has an individual water supply, that mosquitoes observe town boundaries and that no one travels to a place where they can become infected with a rare or emerging disease. Because there is no system in place, the concept of timely disease detection, control and prevention is a farce. I am writing to heartily endorse the efforts of the NJ Department of Health and Senior Services and the many other individuals and groups who have worked diligently over the last 5 years to craft the Practice Standards of Performance as introduced in the January Register. I implore you to adopt the regulations as written." (93)

RESPONSE: The Department thanks the commenters for their support.

COMMENT: Twenty-six commenters, representing health education professional organization, universities and individual health educators, expressed their full or strong support of the rules with particular support for N.J.A.C. 8:52-6, Health Education and Health Promotion, and related N.J.A.C. 8:52-3 and 4 concerning staffing and credentialing requirements for health educators practicing within the New Jersey public health system. The overwhelming majority of these commenters expressed the importance of requiring local health departments to employ or contract for the services of certified health education specialists (CHES). (11, 18 through 22, 40 through 52, 54, 56, 58,109, 110, 111, 112)

RESPONSE: The Department thanks the commenters for their support.

COMMENT: Two commenters expressed strong support for the requirements of the rule that support an adequately staffed and properly qualified public health workforce as outlined in N.J.A.C. 8:52-3.2, 4.1 and 4.2. (4, 12)

RESPONSE: The Department thanks the commenters for their support.

**II. Process**

Twenty-four commenters provided comments regarding the process the Department used to develop these rules. (3, 13, 14, 15, 28, 29, 57, 60, 64, 66, 69, 70, 72, 76, 83, 86, 89, 91, 94, 95, 97, 99, 106 and 108)

COMMENT: Many of these comments were about the need to discuss and analyze the results of the demonstration project prior to adoption. One of these stated that the

Department should have made the results of the demonstration projects available to all health officers for their evaluation prior to adoption of the rules. One other stated that complete reports and plans from the demonstration projects should have been made publicly available prior to adoption of the rules. Another stated that demonstration projects should have been operationalized before adoption of the rules. Others stated that there was not enough time after the demonstration project to discuss and analyze the results before the rule proposal was published.

RESPONSE: The Department's intent in sponsoring the demonstration projects was to obtain additional information that could be used to identify operational issues that would need to be addressed to implement the new rule and to identify funding needs for the creation of an effective local public health system. The "lessons learned" through the demonstration projects were used to aid in crafting a number of responses to comments captured in this final adoption package, including but not limited to, conflict resolution processes, phased-in implementation, and funding approaches. Since the terrorist events of 2001, the Department believes strongly that timely implementation of these rules is needed to provide public health protection and prevention services for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. Policy development is an ongoing process and once the rule is adopted and implementation begins, the Department will gain additional information. As indicated, the Department will propose future amendments to the rules where and when indicated.

COMMENT: One comment was received from a demonstration project participant that stated, "My … concern is the impact that these standards will have in a county like … , where a minority of the health officers are reluctant to proceed in what I consider is the 'best for the public health of the overall community.' There is no doubt that the full implementation of these standards will provide the infrastructure building that is needed to achieve a comprehensive community wide public health system within our state. I remain committed to infrastructure building within the … County community, as well as the state of New Jersey." (95) Conversely, other participants from this demonstration project stated that the process used was not open and did not address the concerns of the participants. (3, 76, 86 and 108)

RESPONSE: The Department understands that in a strong "home rule" state such as New Jersey, 100 percent agreement on building a comprehensive countywide community public health system that represents a dramatic change from the current and longstanding approach can not be achieved immediately and without evidence of success to some local communities. Understanding this issue, when the Department developed the "Request for Applications" (RFA) for the demonstration projects, the Department required that "applicants show evidence of support … from local governmental health agencies that represent at least 70 percent of the municipalities within the jurisdictional area." During the course of the demonstration project, 100 percent participation was achieved in both demonstration sites but it was never expected that 100 percent agreement would occur at this point in the process or that all the concerns of the participants could be addressed.

COMMENT: Commenter 108 stated, "Unwieldy GPHP model. It is difficult to make progress on issues with 14 health officers, a consultant, a planner, and other health professionals present at monthly meetings. I do appreciate the concept of the GPHP model and that it was designed for the inclusion of the local health officers such as myself."

RESPONSE: The Department appreciates the commenter's remark. The type of model that the demonstration projects were asked to explore was an open, participatory model. This type of process works well with established partnerships but can breakdown when diverse interests and organizations are involved. The Department believes that this type of model is appropriate but as the demonstration project showed, modifications such as a "conflict resolution" process and modified "rules of participation" are needed if the model is to be productive in all situations. These "lessons learned" will be shared with the public health community and will guide the Department as it develops its implementation plan and technical and consultative services for the effective administration of the new rules.

COMMENT: Several commenters expressed concerns such as these, "I question the need to regionalize countywide or multi-countywide with local employees. Seems more efficient if the Department were to regionalize or bring back the old Regional Offices." Another commenter stated, "The State Health Department closed their northern and southern offices. At one time these offices would assist local and county health departments. …. Why were these offices not reopened or considered as a demonstration project?" (14, 57, 89)

RESPONSE: As stated above, the Department determined that the specialized expertise and capacity to support the local public health system needs to be available at the countywide, multi-countywide or city level to provide consistent Statewide coverage and to allow for timely prevention and response capability. This would be particularly true in the case of a large scale public health emergency. It was determined that providing 22 State regional offices would not be feasible.

COMMENT: One comment was received that stated that before any new standards were established, an assessment should be undertaken of existing practices. Another stated that … " the necessity for change of the current regulations is not supported by documentation. To date, the Department has not demonstrated the deficiencies in the current system." (57, 64)

RESPONSE: The Department has been involved in two formal assessments of local public health capacity in New Jersey. The first was performed by the Department of Health and Senior Services (DHSS) at the local health department level in September 1998, as part of the rule development process. The second was performed July 2001 by the Department of Justice (DOJ) to determine Statewide public health emergency preparedness capacity and response.

In the DHSS assessment, it was shown that personnel resources varied tremendously, with one municipal health department employing one individual and a county health department employing over 300 individuals. The assessment showed a lack of expertise in critical public health professions such as epidemiology, public health planning and information technology. Further, it showed that local health departments scored less than 50 percent in four of the 10 critical organizational practices of public health and just below 50 percent in two of the three main functions of public health (assessment, policy development, and assurance). (Freund, C. & Liu Z., Journal of Public Health Management and Practice, 2000, 6(5), 42-50.)

The DOJ assessment was performed for the local public health system with the 22 Local Information Network and Communications System (LINCS) agencies convening meetings with their public health partners for their LINCS coverage area. The assessment sought information about a community's level of preparedness to detect and respond to public health emergencies including an extensive set of questions built around the Ten Essential Services of Public Health. If the mean response for a question was less than 60 percent, the capacity level for the State was considered poor. In this assessment, New Jersey's overall response rate indicated a poor capacity for 46 percent of the assessment questions.

In addition, throughout the requirements in these rules, a conscious effort was made by the Department and its advisory committees to respect the strengths of the existing system and its components and strive to enhance this system. This commitment to the existing system is clearly delineated in N.J.A.C. 8:52-3.3, Local health agency's minimum capacity, which addresses the functions that local health agencies currently perform and N.J.A.C. 8:52-3.4, Specialized regional expertise and capacity, which provides each local health agency with access to the expertise needed to plan, prioritize, analyze data and investigate public health problems.

COMMENT: Several commenters expressed concern about the process used to promulgate the rules, stating that the 30-day comment period was too short and one public hearing in Trenton was not enough. In addition, a few comments were received that questioned whether communities across the State knew about the rules and stated that Mayors and Councils needed to be fully informed about the rules before they went any further. One commenter stated, "For the record the development of these standards was not an open process. I, for one, was categorically locked out even though I wanted to participate. …" (89)

RESPONSE: The Department believes that the process used for these rules supported the development of sound public policy. Throughout the development of the rules, the Department has made numerous attempts to inform and involve all interested parties about the development and content of the proposed rules. Unfortunately, direct involvement of all affected individuals prior to the proposal of the new rules was not possible.

In 1997, the Department, under the direction of the Public Health Council, undertook a deliberative process to evaluate the existing rules, "Recognized Public Health Activities and Minimum Standards of Performance for Local Boards of Health in New Jersey," henceforth known as "Minimum Standards." A 31-member Public Health Task Force was convened. The Task Force evaluated "Minimum Standards," identified government's unique role in protecting the public health, critically examined New Jersey's local governmental public health system and recommended strategies for system improvement.

The full Public Health Task Force adjourned and using the recommendations of the Task Force, the Department and the Executive Committee of the Task Force developed a working draft of the new rules modeled after National Public Health Performance Standards that were created at a national level through a partnership of State and local public health organizations and the Centers for Disease Control and Prevention.

In August 1999, an 18-member Practice Standards Writing Group met to analyze and recommend modifications to the working draft and the draft was revised. In addition, two opportunities to review and comment on the draft rules were provided to the memberships of all public health professional organizations in New Jersey in February and December 2000 and changes to the rules were made based on these comments. During these comment periods, the draft was publicly available on the Department's website.

Representatives from the Public Health Council, New Jersey Health Officers Association, New Jersey Association of County Health Officers, New Jersey Environmental Health Association, New Jersey Local Boards of Health Association, New Jersey Public Health Association, New Jersey Association of Public Health Nurse Administrators, New Jersey Society for Public Health Education and academia were involved in the above processes. As part of their involvement, these associations acted as conduits of information about the development of the new rules to their peers. In addition, health officers conveyed information to their local board of health and governing bodies.

During the process, the Department also conducted focus groups with mayors, health officers, and other public health professionals and met with officials from the League of Municipalities.

Based upon the effort the Department made to provide an open and public forum throughout the development of the rules, the Department used the routine format for publication of new rules which was a 30-day comment period with one public hearing in Trenton. Once the rules were published in the New Jersey Register, the Department received requests to extend the comment period to 60 days and have multiple hearings throughout the State. These changes would have required additional notification in the New Jersey Register and would have delayed the process at least an additional two months. To ensure that all comments were addressed, the Department has included all comments received after the 30 day deadline. (Note: Since the publication of the notice of proposal, the Department has adopted a 60-day comment period.)

COMMENT: Two comments were received that were very complimentary to the Department about the process used to develop these rules. One commenter stated, "I have been part of the process since 1997 and am so proud to see this day finally come. … 'support the process and standards' and recommend that 'once implemented that the process remain fluid and health officers and others given opportunity to provide feedback on a continuing basis.' " (97) Another stated, "The development of New Jersey's proposed Public Health Practice Standards went through a process I have not seen during the past quarter of a century. …. years spent on the process – carefully researching performance standards, including all the public health organizations in the process, providing two opportunities for review and comment, and piloting the standards in two very different counties. The Practice Standards truly are a collaborative effort and the result of a very open process." (13)

RESPONSE: The Department appreciates these commenters' support and, as suggested, intends to maintain a fluid process that allows the public health community the opportunity to provide feedback on a continuing basis.

**III. Existing Minimum Standards**

COMMENT: Five comments related to revising the existing Minimum Standards were received as an alternative to adopting the proposed new rules. (3, 69, 80, 89 and 90) One commenter stated "The current "Minimum Standards of Performance" are very precise about the delivery of public health services to our communities. They should be revised with the Proposed Practice Standards put on hold until they are feasible without unnecessary costs to the municipalities… ." (69) Another stated, "Our boards and our communities would like the State to focus on improving the current minimum standards to render them more effective and to factor in current trends to include health issues related to bioterrorism. One way to do this would be to develop an efficient tool to monitor and audit services currently in place, such as CEHA, disease surveillance, comprehensive data collection and data analysis." (3) One of the commenters was also concerned that the new "Practice Standards" would weaken the core of local public health expertise that has evolved since the "Local Public Health Services Act, P.L. 329, (1976) went in effect April 1, 1978 [P.L. 1975, c. 329 effective April 1, 1976]." (90)

RESPONSE: As part of the process to develop the rules, existing Minimum Standards were evaluated. As stated above, they had not been substantially revised since 1986. It was determined that the rules were prescriptive, requiring programs and services to be performed without any consideration of an existing community need. The prior rules promoted independent functioning of each local health agency in the State with no systematic approach to creating effective communication and coordination when public health issues crossed jurisdictional boundaries. Additionally, the rules did not reflect the changing role and responsibilities of local health agencies and new performance expectations that were being developed. Based on this, it was decided that it would not be possible to amend the then existing chapter to reflect current public health practice and new rules needed to be developed.

## IV. Cost and/or Funding

COMMENT: One commenter, strongly in support of Practice Standards, stated the following, "Clearly, adequate funding to implement these significant changes to the way we do our work is necessary. But, I truly believe that one of the main reasons that public health in New Jersey keeps falling off the health care agenda and had not been able to mobilize much financial support is that we are a fragmented and unaccountable collection of health departments. The new Practice Standards are designed to address these critical weaknesses. The proposed standards will create a true public health system**.** They will allow the public and policy makers to hold public health accountable for the public's investment in public health.

The issue of funding can be viewed as a cup half full or half empty. There are those who see the new Practice Standards as yet another unfunded mandate. Yet, I believe most health officials in the state view the standards as the greatest opportunity public health has had in years to influence the health of the entire population in New Jersey. The services provided by public health are too vital to the health of our citizens for us not to move forward with these standards. …" (22)

RESPONSE: The Department appreciates this commenter's point of view.

Thirty-five commenters provided comments about the costs or the need for funding to support implementation of the rules. (3, 5, 7, 14 16, 17, 23, 24, 28, 29, 30, 33, 35, 57, 58, 60, 63, 69, 73, 75, 76, 77, 78, 79, 80, 84, 85, 91, 92, 94, 95, 96, 98, 99, 100 and 101).

COMMENT: Twenty-three commenters expressed support for the rules but were concerned about the need for an identified stable source of funding prior to adoption of the rules. Of these, some suggested the creation of a strategic plan to fund the rules or that the department needed a clear idea of implementation costs over the next five years.

Several commenters from one of the demonstration projects stated that the Practice Standards should go forward but stressed the need for Federal and State funding to implement the rules. One commenter stated, "While I can not speak for the others in Bergen County, I think that a significant part of the difficulty that we encountered in our project is symptomatic of the weaknesses of the current public health system, particularly funding. … I support the proposed Public Health Practice Standards on the condition that the State provide a permanent strategic funding plan for implementation of these new rules." (100)

Many commenters specifically questioned how additional positions (epidemiologist, computer specialist, public health planner, director of public health nursing, health educator, and a medical director) would be funded. One stated, "You can show good faith by agreeing to fund these major positions in each county." (60)

Six comments from participants of the Bergen County demonstration project stated that they were very concerned with costs and the source of funding for these rules and did not believe that the rules should go forward. Several stated that the projected cost for implementation of the rules in the business plan was cost prohibitive and that the Department had the responsibility to estimate the costs of the changes and provide funding. Several acknowledged that certain services and programs should be assigned to the county or regionalized since this would be beneficial and cost effective but stated that the State should invest funding in them. Several noted the difference between the estimated costs of the two demonstration projects of $500,000 and $1,425,722 and stated that the implementation costs of $2.00 per capita for one of the demonstration projects was unrealistic.

RESPONSE: The Department realizes the need for stable funding to support implementation of the rules. For the period of August 31, 2002 through August 30, 2003, a total of $11,643,843 from Federal and State funds has been made available in the form of financial and direct assistance to Local Information and Communication System (LINCS) Agencies. Of this, $8,955,404 in Health Service Grants has been provided to LINCS Agencies to hire an epidemiologist, LINCS Coordinator, Information Technologist Specialist and Health Educator/Risk Communicator. In addition, LINCS Agencies can choose to request funding for administrative support, operating expenses or other staff, such as a medical director. The other $2,648,030 is being provided to LINCS Agencies as direct assistance in the form of a Department Planner/Coordinator and New Jersey Institute of Technology (NJIT) information technology services.

This assistance will help LINCS Agencies build the specialized expertise and capacity required at N.J.A.C. 8:52-4.1(b) to develop regional disease surveillance, communication systems, risk communication, education and training and provide area-wide (countywide, multi-countywide or city-wide) public health protection and prevention services for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. Continued funding is anticipated on an annual basis.

In addition, the Department will be spending $4,463,867 to support the operations of local health departments. Funds will be used to: enhance the Statewide Communicable Disease Reporting System and provide rapid real-time reporting of communicable diseases from laboratories, hospitals and local health departments ($1,900,000); develop new applications for outbreak investigation protocols and guidelines, data collection protocols and enhance LINCS ($412, 570); purchase and install high speed Internet connections and computers for the 92 non-LINCS local health departments and provide each LINCS Agency with blast fax and auto-dial capabilities and PDAs ($851,297); develop risk communication skill development and training for State, regional, and local health department staff including train-the trainer programs and various print materials for public distribution ($175,000); develop and deliver a public health worker "Bioterrorism Certificate Program," develop and deliver a training needs assessment, expand the distance learning network, market training and education to targeted audiences; and develop and deliver program activities that foster linkages between health care associations, local health departments, LINCS Agencies, public health nurses, health

educators, laboratory workers, and other allied health care providers to improve collaborative preparedness, planning, incident identification, and response. ($1,125,000*)*.

The Department believes that this $16,107,770 in new funding to build public health infrastructure shows that it has acted in good faith to support implementation of the rules. In addition, the Department agrees with the suggestion of developing a strategic funding plan and is willing to further explore this matter. However, it should be noted that during rule development, the Department made several attempts to quantify costs and only anecdotal information was available. As such, it was determined that additional funding needs could not be determined without implementing and evaluating the impact of the rules.

Regarding the difference in estimated costs for the two demonstration sites, additional information that may not have been available to the commenters must be considered when comparing these costs. Morris and Bergen counties have, for example, very different population sizes, 470,049 and 844,118 respectively (New Jersey Department of Labor, Census 2000 Data for New Jersey, April 2001) and the goals and objectives of the business plans were very different. After evaluating the business plans of these demonstration sites, the Department determined that the best way to begin implementation of the rule was to provide Statewide funding as previously mentioned for the regional expertise and planning that will be needed to develop the local public health system. As the development of the system proceeds, the Department will be in a better position to evaluate additional funding needs and to determine a funding plan.

COMMENT: Several commenters stated that full compliance by the local health departments should not be required until stable funding is provided and that Public Health Priority Funds should not be diverted to fund implementation of the proposed rules. In addition, several stated that already scarce funds should not be shifted because, as a result, other vitally important public health activities will lose funding. Several were concerned about compliance without resource allocation as reflected by this commenter, "Clearly, resource constraints exist for the implementation of the ideals outlined in the chapter … This further suggests the need for incorporating into this chapter procedures for rebuttal and recourse which local and state health officials can apply, particularly when are found to be non-compliant under prohibitive circumstances."

RESPONSE: As stated in the Economic Impact in the rule proposal, the Department recognizes that some of the components of the proposed new rules may need additional resources to build capacities. In addition, the Department realizes that some of the rules will take time to implement and full compliance will not occur immediately after the rules is adopted. To address these issues, the rules allow for phase-in of certain proposed new requirements and they provide for an outcome based continuous quality improvement process to determine a local health agency's achievement of the practice standards. These mechanisms will give the Department the ability to benchmark each local health department's existing performance and to develop a continuous quality improvement plan that each local health department will need to follow to enhance its performance. In this way, the Department will be able to customize compliance

requirements and improvement plans for each local health department dependent upon their existing capacity and their ability to meet the new standards.

Concerning Public Health Priority Funding, each year the Department, with approval of the Public Health Council, determines use of this funding. As the effectiveness, accessibility and quality of existing programs are evaluated and new critical priorities are identified in the community health improvement planning process required in the rules, use of these funds to address new priorities may occur.

COMMENT: One commenter stated, "Given the emergent new health issues since September 11, 2001, we need to adjust our priorities, without incurring new expenditures. A top priority should include building the public health infrastructure at the local level." (83) Another commenter stated, "8:52 3.4 There is no provision for a local board or local health agency to engage their own expertise and capacities. Many agencies and\or boards either currently have or would gladly require some or all of this expertise and either work with other agencies in the region or provide some of these services on a shared basis. ... As long as there are a large number of boards and agencies, the initiative to participate by providing some of these services should be allowed and encouraged with the caveat that there will be no wasteful duplication. ( 7) One other stated that "At least two sections of the proposed statutes (sic) contain the language 'the minimum unit … for NJ shall be the County ' … This presupposes that not a single local health department is capable of fulfilling these mandates. I think the local units should decide if they have those capabilities or not." (86)

RESPONSE: As can be seen from the funding being provided as discussed above to the 22 LINCS agencies to build local public health infrastructure, it is not possible to build public health infrastructure at the local level without incurring costs since this effort requires hiring staff that can provide specialized expertise and capacity. In addition, the Department believes that funding infrastructure for the 114 local health departments in the State would be cost prohibitive and would not lead to the integrated systems-based public health system that New Jersey needs to protect its citizens from public health threats that cross jurisdictional borders, such as bioterrorism, outbreaks of infectious disease and other public health threats and emergencies.

COMMENT: One commenter was very specific about which sections of the rules should be the responsibility of the Department both financially and through the use of State personnel but provided no data to support these statements. Citations were listed as follows: N.J.A.C. 8:52-3.2 (a)5 i, 7iv, 10ii and iii, 3.4(a), 4.1(b), 4.2(b), 5.2(a)3, 5.2(f) 1 and 2, 5.2(f)3, vii and x, 8.4(b)1, 2 and 3, 9.2, 9.3, 10.2, 10.3(a) and (b), 11.2(e) and (f), 12.4(b), 13.2(a)3, 15.2 and 16.2(c). (75)

RESPONSE: As stated above, the Department has dedicated $16,107,770 in new funding to build public health infrastructure. The Department can not evaluate the commenter's statements since supporting documentation was not provided.

## V. State Mandate/State Pay

COMMENT: Eighteen comments and 13 resolutions were received that opposed the rules on the basis of "State Mandate/State Pay." The following comment expressed the sentiments of most of these, "Without significant State funding … are the local Taxpayers then going to have to pay for the implementation of these regulations? The cost of implementing would be in addition to those potential fiscal hardships the local taxpayer is facing. Consequently, this department must view these regulations as an unfunded State Mandate. This proposal should not be implemented until a permanent funding source is identified other than local taxpayer/local municipality." Another commenter stated, " … I believe the proposed Practice Standards are a prime example of another unfunded mandate and in conflict with Title 52 (Local Mandates 13H-1,2,3). (5, 6, 8, 57, 61, 62, 65, 67, 68, 70, 74, 75, 81, 85, 86, 87, 88, 89) See Section XII below for summary of resolutions.

RESPONSE: The Department believes that the funding level of $ 16,107,700, outlined above, supports the known costs of implementation of the rules.

## VI. Other Support Needed

COMMENT: Twelve commenters stated that for the local public health system to change as these rules require, other support in addition to funding will be needed. (14, 27, 28, 29, 30, 32, 58, 82, 89, 91, 94 and 98). A common theme was that the Department along with local health departments will need to change and modernize. Many of these commenters stated that there was a need to develop the roles, responsibilities and functions of the Department and for a concerted Department and State commitment to support the change. Several commenters stated that these rules are only part of the standards that need to be in place for a truly efficient and effective Statewide system. They further stated that governance and State-level performance standards, that have been developed at the national level, need to be performed and linked to an adopted N.J.A.C. 8:52 so that clear responsibility and accountability at all levels of government can be achieved. One commenter gave suggestions about where there was a need in the rule to develop standards or documents that would define the State role. This commenter also stated that quality control/assurance measures and specific evaluation criteria should be specified or targeted for development and compliance standards set for all levels. In addition, this commenter stated that the specific capacities and performance standards of higher administrative levels are needed, as well as a link between them and local departments to effectively turn theory into outcomes. A few stated that regional and statewide planning and coordination by the Department is needed to provide leadership and to "avoid the development of 21 different county plans with no common thread or direction." Another commenter stated that the State of New Jersey needs to have its own "Master Plan."

RESPONSE: The Department understands that the public health system is a continuum of the Federal, State and local systems and that the system is only as strong as its weakest link. The Department understands and agrees that it needs to continue to enhance its

performance and ability to support local health departments. As such, the Department has taken a number of steps that will enhance its ability to support the local public health system.

As part of the Department's plan for implementation of Practice Standards, the National Public Health Performance Standards Program's (NPHPSP) "State Public Health System Performance Assessment" and the "Local Public Health System Governance Performance Assessment" will be performed. The NPHPSP is a collaboration of public health agencies and the Centers for Disease Control and Prevention (CDC) who have partnered to develop clear, measurable performance standards for state and local public health systems to help ensure the delivery of the "Ten Essential Public Health Services" upon which this rule is based. These assessments take into account the appropriate roles, responsibilities and functions of state public health agencies and local governing bodies. They provide clear, measurable performance standards that will be used to assess the performance of the Department (standards include aggregate health and demographic data measures) and local governing bodies. Information obtained from these assessments will be used to identify the strengths and weaknesses of each of these entities and to develop a continuous quality improvement plan. This, in essence, will evolve into the "Master Plan," that will be used to incrementally build the department's infrastructure and capacity. In addition, since this is a national program, the Department will be provided with information that will measure its performance and the State public health system's performance with other state public health systems across the country.

Funds are being used at the Department level to provide additional staffing for surveillance and epidemiology, health education, risk communication and information technology to allow timely detection and response to bioterrorism, other infectious diseases and other public health threats and emergencies. These staff will develop Statewide teams that include all the LINCS agency staff to ensure integrated and coordinated systems. In addition, one Department planner will be assigned to each of the 22 LINCS Agencies. To ensure a seamless Statewide plan, these 22 planners will report to five regional planners to ensure that all planning efforts are integrated Statewide. Although the primary role of these planners will be to ensure emergency preparedness response Statewide, they will have a dual role and participate in community health improvement assessment and planning with one of their tasks being to assure performance of the local public health system assessment specified in N.J.A.C. 8:52-16.

As stated in the Department's response under "Comments Related to Cost and/or Funding" above, the Department has already begun the process of strengthening its statewide public health systems, such as the Communicable Disease Reporting System.

COMMENT: Four commenters were concerned about the need for timely, accurate and complete aggregate health and demographic data and statistics at the municipal level that are available for analysis and manipulation by the countywide or multi-countywide collaboratives for performance of the community health assessments (CHA) and the community health improvement plans (CHIP). One commenter stated that there was a need for the development of standardized methods for the collection of data before

practice standards are adopted. (29). Another commenter stated, "The CHIP process should be striving to get to the smallest denominator and should attempt to profile every town, township, borough and city to the extent possible. … The process needs to gather National, State, County and local data and focus down as far as possible. …" (28, 29, 89 and 98)

RESPONSE: The Department understands the need for timely, accurate and complete aggregate data. At present, the Department's Center for Health Statistics is providing public use data sets for analysis and manipulation that can be found on its web site at www.state.nj.us/health/chs. The Department is working to improve the timeliness of electronic data that is available through the public use data sets. Provisional data is always available through direct contact with the Center for Health Statistics. The collection of birth and death statistics is governed by the National Standards Set, the Centers for Disease Control and Prevention, the National Center for Health Statistics and the National Association of Public Health Statistics and Information System. The Department will continue to provide appropriate, reliable and statistically sound data.

COMMENT: A commenter was concerned about the statement in the rule, "reporting shall be contingent upon the development of electronic report systems" and requested that target dates for completion be specified and related protocols and templates be developed and made available. One commenter stated the need for the Department to develop a stronger communicable disease reporting system (CDRS).

RESPONSE: The Department understands the commenter's concern about the need for the Department to develop electronic reporting systems. The statement of concern to the commenter regarding electronic reporting appears in N.J.A.C. 8:52-3.2(a) and 5.2(g)3 of the rules. In N.J.A.C. 8:52-3.2(a)1, this statement refers to vital statistics and health status measures of population and sub-populations and as such includes numerous independent reporting systems. N.J.A.C. 8:52-5.2(g)3 refers to all diseases and threats and includes more than one reporting system. The development of these electronic reporting systems depend on many variables, implementation phases and time frames. As electronic reporting systems are developed, the Department uses a variety of methods to ensure that users are proficient in the use of the system. As such, it would be difficult for the Department to implement the commenter's suggestion to include target dates and related protocols in the rule since this would require compilation of this information for multiple systems in various phases of development. The Department continues to improve and enhance its electronic reporting systems. As stated above, $1,900,000 in funding is being used to enhance the Department's CDRS which has advanced from the development phase to production (deployment).

COMMENT: Two commenters had similar concerns that a sustained and committed effort on the part of the State and elected officials is needed and questioned whether the Department would be willing and able to talk to the Governor, Legislature, freeholders and mayors about the benefits and the need for a strong coordinated public health system.

One commenter stated that the Department and the political support of the State will be needed to help counties that experience problems with regional efforts.

RESPONSE: The Department continues to advocate for a strong State and local public health system. This need has been made more real at all levels of government since the September 11, 2001 terrorists attacks and the October 2001 Anthrax incident. As stated above, the Department is committed to working with counties that experience problems with regional efforts and will be developing a conflict resolution system.

COMMENT: "8:52-12 … It is recommended that the State identify state and local policies for working with the media, and that they maintain and disseminate these policies. Those with the roles in communicating urgent messages should be trained in risk communication. Statewide training and peer exchange activities should occur with documentation and accountability." (58)

RESPONSE: As stated above, the Department is in the process of hiring a risk communication specialist that will act as a State coordinator and team leader for the health educator/risk communicators that will staff the 22 LINCS Agencies. These teams will foster Statewide collaboration; coordinate professional and public education and information; develop and facilitate the delivery, and evaluate effective risk communication messages in cooperation with and based on Department protocols; create partnerships with stakeholders (hospital, local medical and public health professional associations, physicians, universities, media, etc) in the LINCS Agency area to foster relationships with communication directors and other appropriate professionals; and create a mechanism to deliver education and messages with "one voice" throughout the LINCS Agency area.

COMMENT: "8:52-13. Connecting People with Services - It is recommended that the State establish a list of critical health services and a core set of statewide access measures. Such information should include the location and specialty of licensed professionals and services. …" (58)

RESPONSE: N.J.A.C. 8:52-9.4 states that each local health agency shall assure that the community public health partnership, established at N.J.A.C. 8:52-9.2(a), develops, maintains and promotes a directory of health service providers and resources that serves the countywide or multi-county wide area. The directory shall address the health priorities as identified in the Community Health Plan. In addition, the Department's Office of Minority Health has identified counties with large minority populations and is working with agencies in these counties to develop resource guides. Guides have been developed for Essex, Mercer, Camden, Burlington, Atlantic and Cumberland Counties. By the end of the year, guides will be completed for Hudson, Union, Middlesex and Gloucester Counties.

**VII. Enforcement**

Nine commenters provided comments related to enforcement. Four comments involved the local health agency's ability to require non-governmental entities (private and voluntary organizations) to participate in the Community Health Improvement Plan (CHIP) and the Community Health Assessment (CHA). Five comments involved the commitment of the Department to enforce these rules.

COMMENT: Four commenters were concerned that although the rules set the framework for local health agencies to form partnerships that include public, private and voluntary organizations to impact health outcomes and to improve the health of local populations, the local health officer or a county health officer did not have the authority to bring private and voluntary organizations to the "planning table." Several of these commenters stated that they did not know how the health officer would "force" non-governmental agencies to participate. (3, 29, 80 and 90)

RESPONSE: Public health partnerships are critical to achieving the public health goals of the State, since it has been shown that a third of all public health activities are performed by entities other than local health departments. In these partnerships, the local health department does not have an enforcement role over other members of the partnership. Rather, it is a collaborative process where the group develops processes and procedures under which it operates and members participate.

It is the intent of the rules to have local health departments be responsible to convene this type of partnership in each countywide or multi-countywide area, facilitate its operation and actively participate in and support it. The Department has mechanisms that it can use to encourage participation of private entities that do not fall under the jurisdiction of this rules and it will use its good will to facilitate the formation of these partnerships.

COMMENT: Commenters (3, 5, 14, 28 and 89) were concerned that the Department would not enforce the rules and that evaluation methods with an implementation plan were not yet established. One commenter stated, "One of our complaints over the years is that there was no monitoring, auditing mechanism built into the Minimum Standards. To date, not a single municipality or county has been taken to task for non-compliance with the current standards. The Department's history in this area is abysmal." (3) Another commenter stated, "We have long felt that the New Jersey Department of Health should develop a means to audit and monitor and ensure compliance across the state. … The State did not do a good job of developing an instrument to measure, monitor and support compliance with the core standards in the past. We do not see it happening this time around either, so be realistic." (5) One other commenter stated, "On what schedule will you do these audits and will each and every one of them be published?" (89)

RESPONSE: The Department realizes that its ability to assess and enforce local health department compliance with the rules is critical to its implementation and the development of a Statewide local public health system. To this end, the Department has set aside funds to hire a consultant to develop an assessment tool that will be used to evaluate and measure the standards of performance of local boards of health and local health departments and their adherence to the rules pursuant to N.J.A.C.8:52-1.4 and

16.2. The assessment tool, once developed, will be administered annually with the LINCS Agency as the unit of assessment for the local public health system and the local health departments as the unit of assessment for basic public health services. Initial results of the assessment will be used as the baseline to determine the capacity of each local health agency against established bench marks. A continuous quality improvement process will be used to incrementally build local health agency infrastructure and capacity. The Department will audit a sample of local health departments for compliance. The Department intends to take appropriate action for continued non-performance and/or an unacceptable "Corrective Action Plan." The Executive Committee has discussed the idea of publishing the audits but no final decision has been made.

**VIII. Competing Commitments**

COMMENT: Four commenters (3, 5, 66 and 90) provided comments regarding competing commitments. One commenter stated, "One aspect of the Practice Standards raises great concern, not only with the Board (Local Board of Health) but with the City that funds our programs. The role of the Health Officer will change considerably and to do more administration, planning, assessment, taking the Health Officer out of the office, and unable to deal with the regular and basic functions of this department. We take issue with these changes." (5) Another commenter stated, "The level of organization and administration of the county-wide CHA or CHIP will involve tremendous investment of time, travel, and other costs that does not make this feasible. The health officer would have to neglect tasks and other responsibilities at the local level in order to give attention to the requirements of the Practice Standards as it relates to issues county-wide." (3)

RESPONSE: Assessment and planning are two of the fundamental responsibilities of a licensed health officer who functions as the chief executive of a local health agency. Planning relies on the ability to collect and analyze information and to make decisions and take action based on this information. As part of this role, health officers routinely attend meetings with their peers. The Department believes that the health officer's attendance at community health assessment and planning (CHA, CHIP) meetings is important to assure that local concerns are addressed. However, during the development of the rules, local health officers stated that the requirement to attend monthly meetings might be burdensome and in some instances not possible because of a local issue that might arise. To address this issue and to provide local health officers with some flexibility, the definition of "actively participate" in N.J.A.C.8:52-2.1 allows the local health officer to have a "designee" that can attend these meetings. The "designee" is defined in N.J.A.C.8:52-2.1 as "… one or more licensed public health professional(s) employed by the local health agency who act on behalf of the health officer of that local health agency; or one or more licensed health officer(s) employed by one local health agency who agree to act on the behalf of a licensed health officer employed by another local health agency." By providing health officers with this flexibility, health officers advising the Department felt that they would be able to serve their community's needs while participating in the planning process.

## IX. Jurisdiction

COMMENT: Nineteen commenters (3, 5, 8, 28, 62, 63, 64, 65, 66, 68, 69, 70, 74, 76, 79, 84, 90, 99 and 108) provided comments about changes in jurisdiction that would result from the proposed rules. Sixteen of these comments were from participants of one of the demonstration projects. Of these 16, seven were from the same municipality. Most of these comments were related to a realignment of local autonomy or "Home Rule" from the municipality or local board of health to a county entity. Several of the commenters from the same municipality mentioned that it was the intent of the Department to dismantle local health departments and force them into a regional model.

One commenter stated, "Our communities and boards have concerns that the tasks and responsibilities of their health officer and staff should not be controlled or directed by a county agency. Title 26 puts this responsibility in the hands of the local board. This feature should not be reassigned to the County. … It would appear to all of us that the Standards are county focused. In at least two sections of the standards, it is stated that the minimum unit for health assessment and health planning 'will be the county.' We interpret this as reducing the powers of the local boards of health and diminishing their role. This is contrary to an extremely strong 'home rule' in … County and the entire state." (3) Another through a board of health resolution stated, " Whereas the new proposed Public Health Practice Standards, which purportedly are designed to provide a rationalized and systematized approach, may lead to the reduction of local control over the delivery of health services …" (68) One other commenter stated, "… Standards are hindered by the fact that New Jersey is a home rule state. Therefore, there will always be a clash in those counties where there are local health departments and a county health department unless the state intervenes and there is a compromise between all players. Local health departments need to maintain a degree of authority as presently exists in law. There's always going to be dissonance if the "selected health agency" has authority over the local health departments for which there is no statutory basis. The concept of home rule needs to be acknowledged and embraced in order to have any hope of widespread support by local health departments." (99) Several asked whether the State Health Department would provide a conflict resolution team to community public health partnerships … " ( 28, 99 and 108)

RESPONSE: The rules, at N.J.A.C 8:52-3.3 and 3.4, are designed to facilitate the provision of basic public health services and adequate regional capacity and expertise so that local health departments could perform the 10 Essential Public Health Services uniformly throughout the State. As such, the rules do not dismantle local health departments, rather they enhance their functioning through access to regional capacity. The Department believes that the rules respect and recognize the vital role individual local health agencies provide in creating effective public health systems. N.J.A.C 8:52-3.4 clearly outlines the type of services provided at the regional level using a "coordination" function and not a "control" or "authority" function.

To minimize costs and to allow for comparison of data with well established data sets at the countywide level, during the development of the rules it was decided that a

countywide or multi-countywide unit should be set as the minimum unit of analysis in the community health assessment subchapter, N.J.A.C.8:52-10, and the community health improvement plan subchapter, N.J.A.C.8:52-11, of the rules. These subchapters of the rules do not focus on the powers or the role of the local board of health; rather, they provide the basis for determining the most pressing public health problems in an area. This provides flexibility to local health professionals and community leaders to determine the public health programs and the allocation of their resources needed in their community.

The Department understands the importance of "home rule" and local control. However, as shown in the recent September 11, 2001 and October 2001 terrorists attacks, public health threats are not limited to a local jurisdiction and many local jurisdictions do not have the capacity to effectively respond to these issues individually. N.J.S.A. 26:3A2-2 states, "The legislature declares the policy of this State is to assure the provision of a modern and manageable array of public health services to all citizens of the State and to encourage the efficient delivery of such services by areawide health departments where such arrangements are needed to enable municipalities to meet 'Standards of Performance' as determined by the Public Health Council." Accordingly, the Department and its partners developed rules that meet these policy requirements.

The Department agrees that there is always the potential for dissonance in counties that have more than one health department. Consequently, the Department will be taking steps to develop a "Conflict Resolution" protocol to resolve conflicts when they arise. In addition, as stated above, the rules are not written so that the regional local health agency has authority over the other local health departments in the county. Oversight over all local health agencies will be maintained by the Department under N.J.A.C. 8:52-1.3, Compliance, and N.J.A.C. 8:52-1.4, Performance monitoring. However, for the local governmental public health system to function in an integrated and coordinated fashion, a method of accountability needs to be determined by all the participants to ensure that all members are meeting their roles and responsibilities. In this instance, when issues arise that can not be resolved by the partnership, the Department will use the "Conflict Resolution" protocol to resolve them. If an issue arises, where one of the partners does not perform/participate in accordance with the rules, the Department will be responsible for taking the necessary actions to foster compliance and improverelationships.

## X. Legal Authority

Nine comments were received that challenged the Department's authority to regulate local boards of health in several areas including registration, training and adherence to the provision of services specified in the Community Health Improvement Plan (CHIP).

COMMENT: One commenter stated, "8:52-1.5 Registration of the local board of health to include the information required under (b) 2-9, including experience, education, training relevant to public policy, schedule of meetings, etc. is an attempt to regulate who can be a member of the board of health and how they should function even though this is established by the NJ State Legislature under N.J.S.A. 26:3.1 et seq. and not a function of

the Department. … 8:52-8.2 (b) Requiring the local board of health to report the status of training of each local board of health member to the Office of Local Health goes beyond the statutory requirements contained in N.J.S.A. 26:3.1 et seq." (75) Another commenter stated in relationship to experience, education, and training relevant to public policy development, "8:52-1.5(b) 2 These requirements have not been a consideration when governing bodies appoint board of health members. What happens when the board of health is the governing body? … 8:52-1.5 (b)9 - With over 500 local boards of health in New Jersey, it would be more practical that the State would be contacting the health officer rather than the board of health unless there is a specific reason why the State needs to contact them." (28)

RESPONSE: The Department disagrees with the premise that N.J.A.C. 8:52-1.5 is an attempt to regulate who can be a member of the board of health and how they should function. N.J.S.A. 26:3A2-10 states, " the commissioner shall provide an evaluation form to every municipal board of health for the purpose of measuring said municipal boards' compliance with said 'Standards of Performance'." There are no requirements in N.J.A.C. 8:52-1.5 that sets standards. This rule is only for information gathering purposes and it will apply to all local boards of health including governing bodies. This will allow the Department to have readily available information on each local board of health. This information is necessary so that the Department has the ability to contact the local public health policy boards in the state. It will also be used to assess the training needs of local boards of health and to develop appropriate training courses. In addition, comments received during the rule adoption process support the need for the Department to have the ability to contact local boards of health directly concerning public health policy and to ensure that adequate training is available.

COMMENT: "8:52-8.4 (c) The requirement that each member of a local board of health shall participate in a leadership orientation class and participate in on-going training course not only goes beyond the statutory authority of the Department contained in N.J.S.A. 26:3.1 et seq., but are not feasible requirements to impose on a volunteer appointed to a board of health or an elected council member serving in a position as a board of health member." (75)

RESPONSE: As described in N.J.S.A. 26:3-31, Enumeration of specific powers and duties**,** Local boards of health in New Jersey have the inherent general authority to conserve and protect the public health. As such, the Department strongly endorses the need for leadership training and the participation in ongoing training courses. The Department has clarified the wording in N.J.A.C. 8:52-8.4 (c) to make clear the voluntary nature of this participation. The Department recognizes that it can not force members of a local board of health to participate in leadership orientation.

COMMENT: "Sections 11.2 (b) and 11.2 (e) and section 5.2 (b) 1. make the Community Health Improvement Plan, CHIP, have a legally binding effect on the Local Boards of Health. Thus, the CHIP becomes a quasi-legal regulatory document. I think this legally binding requirement does not pass legal muster if challenged at any court at any level.

Whoever the body is that prepares the CHIP does not have legal authority over a local board."

RESPONSE: The Department does not agree. The CHIP is an articulation of Standards of Performance, promulgated pursuant to N.J.S.A. 26:3A2-10 and 13, that are required to assure that services provided are appropriate for the population served.

COMMENT: "8:52-11.2 (h) – The Department does not have the statutory authority to restrict a local board of health from providing services not addressed by the Community Health Improvement Plan. The local board should not be required to obtain permission from the Department in order to provide a service that the local board of health deems necessary for the residents of their community." (3, 75, 80 and 81)

RESPONSE: The Department's intent in N.J.A.C. 8:52-11.2 (h) is to assure that services provided are appropriate for the population served and not to restrict local boards of health from providing services that are needed in their community. The Department will be clarifying the language to achieve this goal.

COMMENT: "The Office of Local Health is being given unusual powers over not only Health Officers, but local boards of health. I suspect some of the regulations require statutory authorization, because there is an attempt to re-write the political structure and relationships through sections of this document. That shows a lack of basic understanding of the local forms of government. You need to consult with some experts as to the impact of the Faulkner Act, in particular, on some of your proposals." (89)

RESPONSE: N.J.S.A. 40:69A-26, Laws Governing Adoption of Optimal Government commonly known as the Faulkner Act, dictate how municipalities and local governments are organized and structured. As such, this law has no bearing on the ability or authority of the Department to promulgate rules as required under N.J.S.A. 26:3A2-1 et seq.

**XI. Issues Raised that are Outside the Authority of N.J.A.C. 8:52**

COMMENT: "… Accountability, enforcement, resource decisions, personnel and staff, professional education and training: indeed all functioning aspects of a local health department should have a companion provision that outlines standards for practice and accountability at all levels. While it is recognized that many such provisions are addressed in other documents or policies their inclusion directly into Chapter 8:52 seems logical. … Even less is said regarding the manner in which the State will provide the 'glue' linking local systems, into a larger functioning machine. Finally, there is also a marked omission of a linkage between the public and the activities of both state and local health departments in this systems approach." (58)

RESPONSE: The Department agrees that it needs to continue to enhance its performance and ability to support local health departments. As stated above, to provide a mechanism of accountability, the Department will be performing the National Public Health Performance Standards Program's (NPHPSP) "State Public Health System Performance

Assessment." In addition, as stated above, 22 Department planners/ coordinators will be assigned to provide a coordinated and cohesive system. Since N.J.A.C. 8:52 represents standards of performance for local boards of health and local health agencies, it is not appropriate for the Department to include these types of requirements in the rules. However, when possible, the Department will define its role in guidance or companion documents to the rules.

COMMENT: "8:52-9 … The role of the State facilitating and supporting the partnership process should be identified and clearly delineated in this standard. … In short, any reasonable role for the State to assume should be incorporated into the standard along with the expected role of the Local Health Officers." (58)

RESPONSE: As stated above, the Department understands that its support is critical to local health departments. N.J.A.C. 8:52 represents standards of performance for local boards of health and local health agencies. As such, inclusion of the State role into these requirements is not appropriate. However, when possible, the Department will define its role in guidance or companion documents to the rules.

COMMENT: "8:52-15 … This subchapter should include standards for operational implementation of findings at the State level. Similarly, the relevant State office should adhere to standards regarding establishing and maintaining advantageous linkages with institutions of higher learning." (58)

RESPONSE: The Department routinely conducts scientific research and acts as any scientific research institution to disseminate its findings. The Department also has established formal linkages with institutions of higher learning. As stated above, inclusion of these State policies into this subchapter is beyond the authority and scope of this rule.

COMMENT: "8:52 12.2 A2 (sic) EMS. . should be specifically mentioned in this section since in many cases they will function as a surveillance and or intake agency and are of primary concern in emergency response." (7)

RESPONSE: The Department agrees that emergency medical services are a critical component of emergency response capability. However, it is not within the authority of these rules to include emergency medical services.

**XII. Resolutions**

Twenty-one resolutions were received from local boards of health, associations and municipalities.

COMMENT: All nine of the resolutions supporting adoption did so because the rules reflect the current science of public health and provide for the establishment of an integrated systems-based public health infrastructure that provides coordinated responses to emerging issues that all local health agencies face, such as West Nile Virus and bio-

terrorism. These resolutions strongly encourage the Department to provide adequate funding to cover potential costs associated with the implementation of the new rules. (Commenters 113, 115, 116, 117, 128, 129, 130, 131 and 133)

In 11 of the 13 resolutions that did not support adoption, it was stated that the intent of the rules were supported but since there were no significant or realistic fiscal resources available to support implementation, the rules were being strongly opposed as an unfunded mandate. One of the remaining two resolutions was not in support because there was no permanent funding, the results of the pilot project were not published, State regional offices were not reopened or considered as demonstration projects, funding for each county might run as high as $2 million, the rules are an unfunded mandate and the need for change is not supported by documentation (127). Concern was expressed in the other resolution about the autonomy of the local jurisdiction, decisions concerning the needs and services for the local population being taken over by the county, and assurance of funding so that the local municipality will not incur additional costs for implementation creating a burden on the taxpayer. (Commenters114, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 132 and 134)

RESPONSE: The Department believes that the $16,107,770 dedicated as new funding shows that it has acted in good faith to support implementation of the rules. In addition, similar themes and concerns of the two dissenting resolutions have been responded to above.

**XIII. Comments on Specific Sections of the Rule**

COMMENT: Commenter 2 requested that the experience for public health nurse, graduate nurse, public health and public health nursing supervisor in N.J.A.C. 8:52-4.2 (b)3, (l)3 and (m)3 be changed from specified years of experience (one to three years) to "documentation of recent experience in public health."

RESPONSE: The Department does not agree with the idea of replacing specified years of experience with the general language suggested since it is common practice in Department of Personnel job specifications and other venues to use years of experience as a criterion to differentiate entry level from higher level positions.

COMMENT: Commenter 2 requested that the language, "Each public health nurse shall complete 15 contact hours of public health related instruction annually" be changed to "continuing education activities must be approved by an organization accredited as an approver or provider in nursing continuing education by the American Nurses Credentialing Center Commission on Accreditation."

RESPONSE: A wide range of skills and competencies are required by public health professionals. Some of those most related to public health nursing include: communicable diseases, maternal and child health, chronic diseases, home and community based alternatives to nursing facilities, the health problems of older adults and disabled persons, the promotion of wellness and health in older adults, public health

leadership and management, community partnerships, coalition building, the use of data in policy development and decision making, continuous quality improvement, cultural diversity, integration of health delivery systems, outcome measurements and evaluation, etc. In reviewing these skills sets and others relevant to other public health professionals, the Department determined that to maintain competency, public health professionals would need to have 15 contact hours of public health instruction annually. The Department has set this minimum number of contact hours for all public health professionals based upon these skill sets, as specified in N.J.A.C. 8:52-4, and believes that it should be consistent across all public health disciplines. As such, the Department does not agree with this comment.

COMMENT: "… The requirements to remain competent and/or to develop further competencies, including leadership and management skills, should be the responsibility of the public health system. There should be funding available to develop and maintain these competencies as this will ensure the highest level of disease/injury prevention and health promotion for the citizens of New Jersey, and the best insurance against workplace incompetence. To place the burden of the financial responsibility on the individual is unfair and unrealistic, given the notoriously low salaries that are common in the public health workplace. … " (17, 33, 35, 36, 37, 39 and 103).

RESPONSE: The Department agrees that competencies, including leadership and management skills, should be defined and developed by the public health system. The Office of Local Health has and will continue to have an active workforce development program. In addition, as stated above, the Department will be spending over $1,100,000 to perform a training needs assessment; expand the distance learning network; market training and education to targeted audiences and provide other related workforce development activities. However, this issue was discussed extensively during rule development and it was determined that it is beyond the authority of these rules to dictate that costs associated with training be paid by the local health agency since this is primarily an employee contract issue.

COMMENT: "There is a need to make a strong statement about taking an integrated approach to planning so that internal expertise, which will have the most intimate knowledge of the state of the public health in the jurisdiction, will not be inappropriately omitted. The following addition to 8:52-5.2(a) is, therefore, requested:
"... Collaboration with the leaders of each of the public health professions in the local health agency (public health nursing, health education, epidemiology, registered environmental health specialist) will ensure that the most accurate information will reflect the current state of public health in the jurisdiction." (17, 33, 35, 36, 37, 39 and 103).

RESPONSE: The Department agrees that local health agencies should use an integrated approach to planning using internal expertise as needed. However, this issue was discussed extensively during rule development and it was determined that it is beyond the authority of these rules to dictate this type of issue since it is a management decision and is not appropriate for inclusion into the rules.

COMMENT: "The first statement" of N.J.A.C. 8:52-5.2(c) "contains superfluous and misleading language. The practice of public health which deals with a population based approach is nothing like the practice of medicine which addresses the state of health of an individual, or often, is limited to a specific organ or bodily system. The clause 'like the practice of medicine' in the first sentence should be deleted." (17, 33, 35, 36, 37, 39 and 103).

RESPONSE: The language in this section does not state that the practice of medicine and public health are the same. Instead, it uses a comparison between the two to make the point that public health professionals have a vital job and as such these professional should be trained and licensed. The Department believes the wording is appropriate as written.

COMMENT: "The local public health agency's role in assurance of access to clinical prevention services is not clearly evident in the current wording of 8:52-13.2. The language 'dances around' the provision of direct services by the local public health agency for those vulnerable populations and those who 'fall through the cracks' . . . Without the provision of direct services when such services are not available in the healthcare system, the safety net of public health is lost. …" To clarify this, the commenters requested that the following language be added as a new N.J.A.C. 8:52-13.2 (a)7. "Assure access to clinical preventive services to vulnerable populations by facilitating access to existing such services when possible, and by providing direct services when the need is not or cannot be met by the existing system." (17, 33, 35, 36, 37, 39 and 103).

RESPONSE: The Department agrees that a "safety net" is needed to provide clinical preventive services to minimize the spread of infectious diseases. The commenter's suggestion was extensively evaluated by the Practice Standards Writing Group through a careful deliberative process. The outcome was such that a consensus emerged that mandating direct services as mentioned by the commenter could have a significant and possibly overwhelming financial impact on local health agencies. As such, the Department does not intend on moving forward with this suggestion. However, this matter will be carefully monitored and studied and possibly considered in future rulemaking.

COMMENT: Comments were received that stated that the language in N.J.A.C. 8:52-7 was vague and did not clearly relate to public health nursing activities. These commenters stated that a previous draft more clearly articulated how and where public health nursing functions carried out the Ten Essential Public Health Services. (33, 35, 36, 37, 39 and 103).

RESPONSE: Since many of the roles and responsibilities of public health nurses and educators are not defined in statute or rules, it was determined that a subchapter for each of these professions should be included in the rules. During the development of these subchapters, the Executive Committee decided that it would be more appropriate to

develop “Best Practice” documents that provide the “how” and “where” or the implementation documents for these specialties. These documents, when developed, will be promulgated and adopted by reference into the rule.

COMMENT: “Best Practices” adoption by reference leaves much to chance as to the actual functions of public health departments in the future. (7 and14)

RESPONSE: Adoption by reference into the rule does not change the ability of the Department to require compliance. There were two reasons why this type of format was chosen. First, since the rules set the public policy for local health agencies and local boards of health, it was determined that a separate “implementation” or “Best Practice” document would be appropriate. Second, the development of “Best Practice” documents allows each of the documents to be independent of the rules and each other, thereby making it simpler to revise “Best Practices” when changes in public health practices occur.

COMMENT: “Consideration should be given to a change in section 8:52-4.1b ‘Specialized Regional Expertise’ . . . the position of epidemiologist should be a direct employee of the New Jersey Department of Health and Senior Services assigned to each governmental public health partnership developed from these new standards. This should insure a seamless communication of disease surveillance and reporting between state and local health officials.” (18 and19)

RESPONSE: The Department agrees with the commenters about the need for seamless communication of disease surveillance and reporting between state and local health officials. To achieve this, the Department is continuing to develop its Communicable Disease Reporting System (CDRS) to allow for real time reporting of communicable diseases. In addition, it will be developing epidemiological capacity in the State by hiring additional staff at the State level and providing funds for the hiring of an epidemiologist for each of the 22 LINCS Agencies. These staff will develop a Statewide epidemiology team lead by Department staff so that efforts can be coordinated and integrated across the state. This system has been in place since 1999 on a limited basis and has worked well. The Department had considered directly employing these individuals but has determined that the current scheme is adequate to achieve the desired outcomes.

COMMENT: The services listed in N.J.A.C. 8:52-3.4 would normally be provided by County Environmental Health Act (CEHA) agencies. Since Morris County does not have a CEHA agency, would the State be accessible to Morris County in providing some of these services, such as a health planner or epidemiologist. (24)

RESPONSE: As stated above, as assessment performed by the Department did not indicate that services listed in N.J.A.C. 8:52-3.4 were being performed by most local health agencies. The Department is working with New Jersey’s 22 LINCS Agencies to perform the services specified in N.J.A.C. 8:52-3.4. If for any reason the existing LINCS Agency is not able to build the required capacity and provide the necessary area-wide

services, the Department will consider providing direct assistance. In the case of Morris County, the Department and the DEP have been working with the Morris County Executive to come to a mutual agreement that will allow these services to be provided at the county level.

COMMENT: … "Staffing recommendations should be put forth based upon a ratio of staff to population size. … Recommend that there be one full time health educator for every 27,000 people in any given community being served." (Commenter 25)

RESPONSE: During the development of the rules this issue was thoroughly discussed by the Executive Committee. One of the major problems with using staffing ratios was the lack of scientific data and research that would allow this type of requirement to be used for all the public health professionals listed in N.J.A.C. 8:52-4. Consequently, the Executive Committee decided that it was not possible to put this type of requirement in the rules. If additional research becomes available, the Department will reconsider this issue in future revisions of the rules.

COMMENT: Two comments were received related to N.J.A.C. 8:52-4.2(f). Commenter 28 stated the requirement for information technologists "is not representative of private industry standards." Commenter 107 stated, "Paragraph 8:52-4.2 (f) should be deleted. I do not think the Department has the expertise to set standards for this position."

RESPONSE: The Department respectfully disagrees with these comments. The Department has a large information technology staff that specializes in public health information technology and the development of the public health information technology systems that local health agencies need the ability to use and support. The Department has access to this staff for rulemaking requirements. The Department believes that the requirement set forth in the rule is reflective of the type of information technology expertise needed at a local health agency. If additional data becomes available that supports a change in this requirement, the Department will consider changing the rule in a future rule proposal.

COMMENT: "8:52-15.2(c) – Data sent to researchers may violate HIPAA regulations that govern the privacy of protected health information." (28)

RESPONSE: The Department is required to follow HIPAA regulations. Under HIPAA, consent and authorization are not required for uses and disclosures of protected health information if required for the conduct of public health surveillance, public health investigations and public health interventions for the purpose of preventing or controlling diseases. (Code of Federal Regulations, CFR 164.512(b)(1)(i)).

COMMENT: Commenter 29 stated, "The practice standards should clarify that professional staff, under the authority and supervision of the health officer, will be only responsible for their [respective] area of the ten essential services. Each professional group cannot be responsible for all the essential services. This language creates confusion and grossly overlaps responsibilities."

RESPONSE: The Department does not agree with the commenter because the 10 essential public health services are not categorized by public health professions. Rather, they are practiced as a continuum with each public health professional having a role that supports their implementation and delivery.

COMMENT: Commenter 30 stated, “Under N.J.A.C. . . . 8:52-6.2 and 8:52-7.2, state that the professional staff under the authority of the health officer will be responsible for the provision of the essential services. The Standards do not intend for each group to function independently.” Commenter 91 stated, "In the responses please clarify that staffs from all agencies and all fields are working together. Even though the health education and nursing staffs are responsible for the '10 essential public health services,' it is only as part of the entire agency. Each division is not responsible for the services on their own. It needs to be clarified that coordination activities is (sic) necessary for the '10 essential public health services' to be conducted."

RESPONSE: The Department agrees with the commenters. However, it does not believe this change is necessary since N.J.A.C. 8:52-5.2(a)4 and (b) clearly articulate the authority of the health officer in this regard.

COMMENT: Commenter 29 stated, “Leadership continuing education should only be required for health officers. They are the only CEO of the local health department. It will be costly and unnecessary for other public health staff members to be required to have leadership training.”

RESPONSE: The Executive Committee extensively discussed the need for leadership training across all public health professions to develop the skills that are required to support implementation of the rules. Leadership skills, such as policy development, implementation, and evaluation; advocacy; collaboration; and coalition building, are needed to implement the 10 essential public health services. As such, the Department does not support limiting this requirement to health officers.

COMMENT: “The proposal references several publications which are not regulatory in nature. This again provides a potential legal loophole and detracts from enforcement capability.” (7)

RESPONSE: The Department does not believe that the use of supplemental documents in the rules provides a legal loophole or is a weakness in the rules. Supplemental documents are routinely used in the rulemaking process to provide guidance or to further explain the requirements of the rule.

COMMENT: “8:52 3.1 A&B (sic) …State the policy role of the local board on behalf of local government and its legal relation with the local health agency. This legal linkage must be clearly explained.” (7)

RESPONSE: The concerns of the commenter are addressed in detail at N.J.S.A. 26:3-1 et seq. Since the role of the local board, as stated in this statute, is extensive, the Department did not believe it appropriate to summarize in this rule.

COMMENT: "8:52-5.2 E&H (sic) To what extent does having access to a financial officer or licensed attorney satisfy the requirements for compliance in these areas?" (7)

RESPONSE: Compliance would be based on the local health agency's ability to meet the criteria specified in the rule.

COMMENT: Commenter 7 stated, "Pleased to see a requirement for registration and training of local board members. … 8:52 8.4C (sic) The training for local board members should be more specific and provided on a 3 or 4 year phase in, so that municipalities may comply with term requirements and ultimately comply with a specified requirement."

RESPONSE: The Department thanks the commenter for his support and agrees with the commenter's suggestion. It is the Department's intention to determine the training needs of local boards of health through their registration at N.J.A.C. 8:52-1.5. Courses that are needed will be offered through multiple venues and formats on a voluntary basis to local board of health members. As such, the Department does not believe it needs to revise the rule.

COMMENT: "8:52 8.4 These statements, while noble, are not regulatory and should be either made so or deleted." (7)

RESPONSE: The Department has reviewed the language in N.J.A.C. 8:52-8.4 and believes that it is regulatory in nature.

COMMENT: One commenter suggested "exempting local health departments from the 'Municipal Cap Law' since health department budgets will have to be increased during the 'phased in' implementation of the proposed standards… ." (28)

RESPONSE: The Department can not by regulation create an exemption from a statute. As implemention of the rule occurs, the Department will continue to explore the fiscal impact of the rule and recommend appropriate actions.

COMMENT: "8:52-5.2(f) 2 – Completion of the report by February 15 is not realistic. This date should be changed to March 31." (75)

RESPONSE: The Local Health Evaluation Report is the name of the annual report that local health agencies are required to complete under state statute, N.J.S.A 26:3-35. N.J.S.A 26:3-35 states that this report shall be prepared and filed "on or before the fifteenth day of February in each year."

COMMENT: "8:52-6.2(c) 11 – Serving as a spokesperson and liaison to the media is a function of the Health Officer. Determining if this is to be delegated should be left to the decision of the Health Officer." (75)

RESPONSE: The Department agrees that it is the responsibility of the health officer as the Chief Executive Officer to function as a spokesperson and liaison to the media and determine whether this function should be delegated. As written, N.J.A.C. 8:52-6.2(c)11 provides this flexibility.

COMMENT: One commenter stated, "The proposed regulations 8:52-4.2, public health staffing qualifications, very specifically delineate the titles and qualifications necessary for compliance. However, many existing local health agencies are governed by NJ Department of Personnel (NJDOP) employment rules. Some titles utilized in 8:52-4.2 are not consistent in qualifications to NJDOP titles, and some titles used in 8:52-4.2 do not exist at all in the NJDOP Title Code Book. … the proposed rules do not allow for systems that are already in place that utilize qualified, credentialed individuals in other NJDOP job titles. For example, services such as outreach, case finding … can and are developed and overseen by people with Master's level public health administration backgrounds." (Commenter 98) Another commenter stated, " 8.52-8.3 – Job descriptions are contained in NJ Department of Personnel descriptions. In order for the Health Officer to change, modify, delete or add tasks to those DOP descriptions, permission would have to be obtained in writing from them." (75)

RESPONSE: The Department realizes that in some cases there is a need to develop new or revised job specifications. The Department has contacted the Department of Personnel and is working with them to establish appropriate specifications for new or expanded positions. Specific to the commenter's concern, it should be noted that N.J.A.C. 8:52-4.1 and 4.2 would not prohibit a local health department from utilizing existing staff or hiring other qualified individuals with different qualifications to supplement those specified in the rule.

COMMENT: "8:52-14 …Enforcement standards for the Office of Local Health are missing from this subchapter, and should be similarly explicit to those outlined for the local level. (58)

RESPONSE: This commenter is requesting that the rule incorporate the enforcement authority related to the State Sanitary Code for the Department's Office of Local Health. The Office of Local Health is responsible for enhancing public health services and activities provided by New Jersey's local health departments. As such, it does not have enforcement authority related to the State Sanitary Code.

COMMENT: Commenter 58 stated that there should be target dates by which the State must produce its promised methods for evaluating and determining adherence to standards in N.J.A.C. 8:52-1.4. and that N.J.A.C. 8:52-16 should include target dates for completion of the data collection instrument that will be used to benchmark adherence to standards of performance and for the Local Health Evaluation Report.

RESPONSE: As stated in N.J.A.C. 8:52 -1.4, "A method for evaluation and determining adherence to standards of performance shall be developed by the Office of Local Health as set forth at N.J.A.C. 8:52-16. As such, the same data collection instrument will be used to accomplish the requirements in N.J.A.C. 8:52-1.4 and 16. The development and completion of this data collection instrument is part of the Department's Public Health Preparedness and Response for Bioterrorism Cooperative Agreement (CA) with the Centers for Disease Control and Prevention. As part of the Department's workplan for this CA, timelines have been developed. The target date for completion of this tool is April 2003. The Department declines to include the target date in the rules since this task is already completed and its inclusion in the rules is not needed.

COMMENT: "Because cardiac disease is so prevalent in our society, one of the suggestions I have is to have a requirement that public health nurses all have current CPR certification. It will be a larger resource of people able to respond to cardiac arrest." (102)

RESPONSE: The Department agrees that emergency medical services (EMS) are a critical component of emergency response capability. However, EMS services are governed under N.J.A.C 8:40A and 8:41A. As such, any requirements related to EMS are more appropriately included under those rules.

COMMENT: "8.52-14.2(d) – All public hearings should be clarified to be limited to those being conducted on a Municipal or County level. Since this section references ordinances, these would be locally enacted." (75)

RESPONSE: The rule, as written, is limited to, and focused on, public hearings that affect the practice of public health within the jurisdiction of the health officer. Therefore, the Department does not believe that the rule needs to be amended as suggested.

COMMENT: "The requirement to have an annual public meeting to report the status of our community health is a great idea, however, why don't we leave that to the discretion of each county/local health department (8:52-5.3(C) sic." (86 and 90)

RESPONSE: The Department believes that communication with the public is a critical component of the community health plan since the plan provides goals and objectives for the improvement of the public's health and their quality of life. Without this communication, there is no interaction between the public health providers and those individuals whose health they are charged with protecting. This interaction can also be used to inform, educate and empower the public regarding the health issues that affect them the most. Consequently, the Department believes that the rule as written is appropriate.

COMMENT: "Section 8:52-4.1(b) lists staffing that each health department will require including but not limited to an epidemiologist, I.T. professional and public health

planner". …can they "be part-time employees or contracted services? … Is "there a minimum number of hours per week/month that the services can be rendered?" (86)

RESPONSE: As stated above, the Department is providing funding to each of the 22 LINCS Agencies through a health service grant to provide a full time equivalent for each of these positions. While there is no absolute requirement that prohibits contracting for these services, the terms of the health service grant limit the number of staff that can be contracted for by the LINCS Agency. Additionally, unless otherwise specified in statute, all local boards of health have the flexibility to employ/retain professional services via contract and/or on a part-time basis as long as such arrangements result in the effective delivery of the defined essential public health services.

COMMENT: The APEX community health assessment process is helpful but required an enormous expenditure in manpower. Resources may not be available to complete every three years. (86)

RESPONSE: The Assessment Protocol for Excellence in Public Health (APEX) required in N.J.A.C. 8:52-5.2(a)3 is used to identify the capacity of the local health agency to deliver the services set forth in these rules and to provide information that is needed to develop the Community Health Improvement Plan. During the development of the rules, it was determined that every three years was the appropriate time frame for completion of this assessment.

COMMENT: "8:52-4 … This subchapter gives explicit indication of the requirements associated with members of the local health department staff, with the notable exception of the Local Health Officers themselves. … they are ultimately responsible for all decisions and outcomes; standards for their selection should be at least as explicit as those for other staff." (58)

RESPONSE: The Department agrees with this comment. However, it was determined since qualifications for health officers are specified in N.J.A.C. 8:7, Licensure of Persons for Public Health Positions, these rules should be referenced since they are the source document.

COMMENT: "Although the proposed new rules are to improve the planning process on a countywide or multi-countywide area, the Department has dismantled the planning services which used to be provided to local health departments. The regional LAB's provided this service but were eliminated several years ago due to budget considerations in the Department." (75)

RESPONSE: As stated above, the Department will be developing a Statewide planning network with Department planners assigned to each of the 22 LINCS Agencies. These planners will report to five regional planners to ensure that all planning efforts are integrated Statewide. The Department believes that this planning network will provide the ability to plan locally while coordinating efforts at the county and State level.

COMMENT: "Summary, Paragraph 12: Add 'health education and health promotion' to the sentence. Should read, '… organized into 16 subchapters and provide for subchapters on definitions, public health practice, public health staffing, administration, health education and health promotion, public health nursing, and for each of the Ten Essential Public Health Services.' " (106)

RESPONSE: The Department agrees with the commenter that health education and health promotion should have been included in the Summary that accompanied the notice of proposed rulemaking that was published January 7, 2002. Changes to the Summary in the rule proposal cannot be made at this time.

COMMENT: "Summary, Paragraphs 5 and 7 and any additional instances: Add "Inc." to New Jersey Society for Public Health Education." (106)

RESPONSE: The Department apologizes for this omission. Changes to the Summary in the rule proposal can not be made at this time.

COMMENT: Subchapter 2. Definitions, are too inclusive because commonly used terms, such as advocacy, assure, capacity, competent leadership, data analysis, designee, enforcement, field representative, graduate nurse, public health, health education, health educator, health officer, information technologist(s)/computer specialist(s), local board of health, monitor, policy, public health nurse, public health nursing supervisor, public health planner, surveillance and surveillance system, are defined. Terms should only be defined when they are used differently than is common usage. (107)

RESPONSE: The Department respectfully disagrees with this comment. The need to define common terms was discussed extensively during its deliberations on the rules with both national experts and Department committees. It was determined that to have the ability to measure and evaluate public health practice, it is important to define both commonly and uncommonly used terms to eliminate individual interpretation and to create a more standardized glossary of terms and their meanings.

COMMENT: "Why must a 'local health agency' be administered by a full-time health officer. Might not a health officer serve on a part-time basis in more than one agency?" (107)

RESPONSE: N.J.S.A. 26:3A2-14 states, “Every local health agency shall be administered by a full-time health officer.” This statute precludes a health officer from serving on a part-time basis to one or more agencies.

COMMENT: "Paragraph 8:52-3.4 (a) What does the phrase 'shall have access to' mean? Does it mean 'shall secure or develop'? Is it a promise of what the State is to provide? This does not seem to be a rule as it is written." (107)

RESPONSE: The phrase “shall have access to” in N.J.A.C. 8:52-3.4(a) cannot be interpreted without referring to N.J.A.C. 8:52-3.3(a)10i., which states, “Each local health

agency shall, at a minimum, have the capacity to deliver specialized services consistent with N.J.A.C. 8:52-3.4. This service shall be developed within two years of the effective date of this chapter." In response to the cost issue related to this requirement, as stated above, the Department has funded the State's 22 LINCS Agencies to provide the local health agency with access to this specialized regional expertise and capacity.

COMMENT: "Paragraph 8:52-4.2 (e) 2. Is it possible to work as an epidemiologist other than in a health related field?" (107)

RESPONSE: As the commenter suggests, the term "epidemiologist" is used to define an individual who has the capacity to investigate and describe the determinants and distribution of disease, disability, and other health outcomes. N.J.A.C. 8:52-4.2(e)2, which relates to an epidemiologist's qualifications states, " Have a minimum of two years experience working as an epidemiologist in a health-related field." The phrase "health-related field" was added in the event that an individual educated as an epidemiologist had a career history outside of a health related field, such as in certain research areas.

COMMENT: "Paragraph 8:52-4.2 (h) sets a higher educational standard than is common for a Nursing Director and, often for a Vice President of Nursing." (107)

RESPONSE: The standard for a Masters Degree for the Director of Public Health Nursing is a long standing requirement that appeared in the previous rule, " Recognized Public Health Activities and Standards of Performance for Local Boards of Health in New Jersey." During the development of these rules, based on the performance of the 10 essential public health services required in the rules; and the skills, knowledges, abilities and role of the Director of Public Health Nursing, it was determined that a Masters degree was needed.

COMMENT: "Paragraph 8:52-5.2 (g) 3. iii. is not realistic. How does the Department propose to monitor local health agencies to ensure that they monitor the email at the beginning and end of each day? This 'rule' should be deleted. Agencies will monitor the mail as frequently as they find necessary." (107)

RESPONSE: Timely monitoring of the LINCS Health Alert Network email for public health alerts is critical for the protection of the public health. The LINCS system has been designed with the technological capacity to test and monitor the use of its email system, and the Department can use this to monitor email access.

COMMENT: "Paragraph 8:52-45.2 (i). Why is a rule necessary when the retention schedule is set by statute?" (107)

RESPONSE: The commenter is referring to N.J.A.C. 8:52-5.2(i). The Department developed this rule as a reference so that local health agencies know the statute and the requirements that they must adhere to when retaining records.

COMMENT: Commenter 108 stated, "… I believe that with a few changes, the Practice Standards themselves could become more flexible. Please see the following example: … To minimize costs and for consistency with existing data, the preferred unit of analysis for NJ shall be the county. This does not preclude any municipality or sub-groups of municipalities from performing their own formal assessment. These sub-groups may share and integrate all relevant data with the county-wide agency, but shall not be subjugated to county-wide planning and coordination."

RESPONSE: The Department appreciates the commenter's suggestion. As stated above, the Department believes that countywide planning and coordination is critical to the development of a Statewide public health system and the public health. This, however, does not preclude "sub-groups" from conducting planning and assessment activities deemed necessary and appropriate. This process should "feed" and support larger area-wide planning efforts.

COMMENT: One commenter, an individual educated as a health educator and practicing in this field for more than 30 years, opposed the CHES requirement. The commenter stated, " … While I agree that health educators need a far better recognition, I do not believe in limiting the opportunity of providing services only to those who are carrying the CHES after their titles. … keeping the CHES title has proved to be extremely expensive and not cost-benefit for many health educators. Thus, health educators, while highly competent in their field, are not financially capable to satisfy the CHES requirement. This is particularly, the case for many race/ethnic minority health educators whose services are crucial to the elimination of health disparities." (55)

RESPONSE: The Department respects the commenter's opinion. However, the need to provide health educators that are formally trained and certified was discussed extensively during the development of the rules and received strong support as a means to fostering a competent and technically relevant workforce.

COMMENT: Commenter 34 stated, "… the public health nurse should be defined as a Registered Professional Nurse licensed in State of New Jersey. The reference to 8:52-2 does not mention this requirement. However, reading further, it is spelled out in 8:52-4.2."

RESPONSE: The Department understands this commenters concern. However, the definitions for public health professionals, such as epidemiologist, health educator, nurse etc., were written to outline the role and the responsibilities of these individuals and not their qualifications. Qualifications are outlined in N.J.A.C. 8:52-4.

COMMENT: "The Practice Standards document is not complete unless all the environmental functions of local health departments are defined and appropriately incorporated . . ." into a subchapter, similar to the public health nursing and public health education subchapters. (14)

RESPONSE: Since all environmental health responsibilities are specified in statute and/or regulations, during the development of the rules, it was determined that it would be adequate to refer to these citations without having a separate subchapter. Upon consideration of this comment, the Department agreed that for consistency and clarity a new subchapter should be developed. The Department has met with members of the New Jersey Environmental Health Association to develop the new subchapter. This subchapter has been drafted and the Department intends on issuing a notice of proposal within 90 to 120 days of adoption of these rules.

COMMENT: Five comments were received about the title "graduate nurse public health" and associate versus baccalaureate degrees used in the rules. Commenter 2 recommended that new language be included in the rules to ensure that this title apply only to individuals already on staff and require that all new hires are baccalaureate prepared nurses. In addition, this commenter suggested that the "graduate nurse, public health" title be re-evaluated for role function (based on education) and titling legitimacy since this is not a legitimate title vis-à-vis Board of Nursing regulations.

Commenter 34 stated, "8:52-2.1 Definition uses the term 'graduate nurse, public health.' A graduate nurse refers to a new graduate from a nursing program that has not taken or received his/her license in nursing. Graduate nurses are not hired in a public health setting. I would prefer to see the term 'public health nurse' with a numeric level of 1, 2 or 3 describing the different educational backgrounds (Diploma or Associates; Bachelors; Masters)."

Commenter 38 took objection to the use of the term “graduate nurse, public health to define those nurses who do not meet. . .” the baccalaureate degree qualification in N.J.A.C. 8:52-4(b). They stated “many public health offices have been staffed by nurses who have between 20 and 40 years of nursing experience, the majority of which has been in public health. These are licensed, professional, registered nurses who, until now, have been identified as public health nurses. They have brought a wealth of knowledge, experience and stability to a field that has been eroded over the course of many years by budget cuts, policy changes, and staff reductions and reassignments.” They request that the term be deleted from the proposal and that the rules contain a grandfather clause similar to the one for health educators to assure existing public health nurses job continuity and job security. (38)

In addition, Commenter 2 suggests review of Subchapter 7, Public Health Nursing relative to nursing functions that can be appropriately delivered by associate degree-prepared or diploma-prepared registered nurses to clarify the role of the graduate nurse, public health (associate degree-prepared). As a representative of an educational institution that provides an accredited associate degree program, the commenter does not believe that associate degree-prepared nurses receive the in-depth educational preparation needed to provide the 15 services listed in N.J.A.C. 8:52-7.1(b). This commenter also recommended either eliminating the concept of “working with a preceptor or local resource person" or proposing an alternative that can be objectively and reliably validated.

RESPONSE: The Department included the title "graduate nurse public health" in the rules because it is an existing Department of Personnel title. The Department of Personnel Job Specification 01930 defines this position as follows: "Under close supervision, provides professional nursing services for a public health agency in the home, school, clinic, or health center; does other related duties," and requires "a valid registration as a professional nurse in the state of New Jersey." The Department is in the process of working with the Department of Personnel to revise existing job specifications and add new ones related to these rules. Since this title is an existing title, it may not be possible to eliminate it. The Department acknowledges these suggestions and also agrees that it may be appropriate to further examine the functions of an associate degree-prepared or diploma-prepared registered nurse to clarify the role of the graduate nurse, public health. To resolve these issues, the Department will convene a small workgroup of the interested parties. If necessary, changes will be recommended to the Department of Personnel. All necessary changes to the rules will be considered in future rulemaking since making these types of changes in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002 and cannot be accommodated without a formal reproposal.

COMMENT: Commenter 2 recommended changing the qualifications of the director of health education in N.J.A.C. 8:52-4.2 (h)1 to require a masters degree and suggests that a master's in nursing be added to the list of degrees specified in the rule. Also, during the rule adoption process, two members of the Public Health Council brought to the Department's attention that provisions in N.J.A.C. 8:52-4.2 (d)2 and (i)2 that require a Health Educator to obtain certification as a Certified Health Education Specialist (CHES) need to be reconsidered for their impact on the ability of a registered professional nurse to practice as a Health Educator.

RESPONSE: The Department has agreed to meet with the appropriate parties representing health education and nursing to further examine this issue. The Department will make a report of findings to the Public Health Council within 90 to 120 days of the effective date of the rules. All necessary changes to the rules will be addressed through subsequent rulemaking.

COMMENT: Commenter 2 recommends changing the qualifications of the public health medical director in N.J.A.C. 8:52-4.2 (i)1 to mandate experience in public health since private health practice is significantly different than public health practice.

RESPONSE: The Department agrees that this suggestion should be considered and will evaluate it with the appropriate parties. All necessary changes to the rules will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: Commenter 2 recommends that the Department require that the public health medical director provide evidence of continuing education in a manner appropriate

to that profession and similar to those being proposed for the directors of public health nursing and health education. Commenter 18 stated ". . . Consideration should be given to require physicians to complete 100 hours of Accreditation Council for Continuing Medical Education (ACCME) approved continuing medical education over a two year period. Reference could be made to the legislation requiring BME regulations for physician continuing medical education. ... signed into law following submission of the proposed practice standards to the New Jersey Register." (18)

RESPONSE: The Department agrees that the suggestion has merit and will evaluate it and Section 12 of P.L. 1989 c.300 with the appropriate parties. All necessary changes to the rules will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: Commenter 7 stated, "Language in N.J.A.C. 8:52-1.3(c) concerning the corrective action plan and enforcement actions should be explained in more basic terms that describe the enforcement requirements and the need for them." Commenter 59 stated, "The draft rules do not include a section on how the Department will enforce compliance. …"

RESPONSE: N.J.A.C. 8:52-1.3(c) is the provision of the rules related to compliance. The Department appreciates the commenters' suggestions and will consider additional language in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: "Consideration should be given to provide a frequency for workforce diversity training proposed in 8:52-8.5" (18)

RESPONSE: The Department agrees with this suggestion. This change to the rule will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: "… not included are specified capacities and performance standards of higher administrative offices. Such standards could call for such activities as fiscal advocacy, budgetary guidance, standards or criteria for seeking federal funds as part of budgetary expansion, development and communication of standardized terms, templates, protocols, measures, educational programs or initiatives, etc…" (58)

RESPONSE: The Department agrees with the commenter's concerns, many of which have been addressed under N.J.A.C. 8:52-5, Administrative Services through the requirement of access to specialized personnel, such as an accountant in N.J.A.C. 8:52-5.2(e) and an attorney in N.J.A.C. 8:52-5.2(h). In addition, the rule includes a strong staffing and workforce competency component in N.J.A.C. 8:52-5.2-4 and 8 respectively which we believe operationally should address many of the commenter's concerns. The

Department will, however, further explore the commenter's suggestions to determine their merit and the need to address them in the rule. Necessary changes to the rule will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: "… In the spirit of a larger systems-based approach to public health, the State should be required by standards to routinely outline and describe the public health workforce overall, allowing for comparisons of capacities across jurisdictions and across programs and specialties. Such cohesion across the broader public health system is critical to more accurate allocation of resources, capacity building and systems development. (58)

RESPONSE: The Department agrees that an overall standard for the public health workforce is needed. As such, N.J.A.C. 8:52-3.2(b) and 5.2(c) require that staff competencies for delivering the "10 essential public health services" shall be those set forth in "The Public Health Workforce: An Agenda for the 21st Century and the "Core Competencies for Public Health Professionals." Both of these documents have been developed at the national level and provide the guidance needed to ensure a competent public health workforce to perform the "10 essential public health services." The Department will, however, further explore the commenter's suggestions to determine their merit and the need to address them in the rules. Necessary changes to the rules will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: "N.J.A.C. 8:52-10 Monitor Health Status" … As part of the cohesion and follow-through at the state level, it would be useful to consider including in the standard an annual evaluation of a sample of communicable disease investigations/consultations conducted at the local health level. Such an effort would enable investigation of timeliness and compliance with protocols. Not only is this essential to the process of monitoring health status, but it potentially provides direction and guidance to important professional in-service training needs." (58)

RESPONSE: The Department agrees it is important to assess the quality of communicable disease investigations/consultations conducted at the local level. As stated above, money is being provided to 22 LINCS Agencies to hire an epidemiologist. On of the roles of the epidemiologist will be to provide guidance to all local health departments in the LINCS Agency's area. The Department will monitor these activities and further explore the commenter's suggestions to determine their merit and the need to address them in the rule. Necessary changes to the rule will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: "8:52-11 … It is recommended that this subchapter be expanded to include standards related to aggressively including the public in developing, enforcing and

evaluating policies and programs. Related to this, the State should provide a written protocol that uses health assessment information to guide health policy decisions. They should be accountable by indicating the manner in which State health assessment data link to health policy decisions, health education and health promotion initiatives, legislative activities, budget decisions, etc. The same quality improvement and accountability required at the local levels should be required by standard at the state level." (58)

RESPONSE: The Department agrees with the commenter. These requirements are already included in the rule under N.J.A.C.8:52-11.2(c) which requires that the Community Health Improvement Plan shall consist of a Community Health Assessment as outlined in N.J.A.C.8:52-10.2(d). As stated in N.J.A.C. 8:52-10.2(d), the Community Health Assessment shall be conducted in accordance with standardized methodologies approved by the Office of Local Health. Such methodologies include "Mobilizing for Action through Planning and Partnerships (MAPP)." MAPP is a community-wide strategic planning tool for improving community health. Facilitated by public health leadership, this tool helps communities prioritize public health issues and identify resources for addressing them. This coupled with the Department's performance of the NPHPSP and the development of a Master Plan, as stated above, will be used for quality improvement and accountability at the state level. The Department will, however, further explore the commenter's suggestions to determine their merit and the need to address them in the rule or other guidance document. Necessary changes to the rule will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: "Subchapter 11, Policy Development. In 2000, DEP revised its CEHA rules to require CEHA agencies to submit a County Environmental Health Assessment and Improvement Plan (Plan). … This development and usage of this Plan is consistent with the draft rules. It is recommended that the draft rules be revised to require that the CEHA Plan become part of the Community Health Improvement Plan process for a truly comprehensive public health document." (59)

RESPONSE: The Department agrees with this suggestion. This change to the rule will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: Commenters 30 and 91 stated, "In 8:52-8.4, nursing supervisors are . . . required to have leadership credits. By definition, a nursing supervisor is responsible for the daily management of nursing activities' and may possibly not even have staff under them. Eliminate the leadership credits for this position. Or, conversely, require leadership credits for all staff."

RESPONSE: As stated above, the Executive Committee extensively discussed the need for leadership training across all public health professions to develop the skills that are

required to support implementation. Leadership skills, such as policy development, implementation, and evaluation; advocacy; collaboration, coalition building, and community organization, are needed to effectively implement the 10 essential public health services. The Department believes that this principal is germane to the title and function of nursing supervisors. The Department will, however, further explore the commenter's converse recommendation to determine its merit. Necessary changes to the rule will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: "Mandated dialogue training would go a long way to aid Public Health Professionals in the restructuring of our public health system. I strongly urge that such training be built into the proposed practice standards." (86 and 95)

RESPONSE: The Department agrees with this suggestion but needs to explore this type of training further. Once additional information is obtained, this change to the rule will be considered in future rulemaking.

COMMENT: In the Appendix under "Infants and preschool children," the reporting frequency should be changed from monthly to quarterly to reflect current practice. (105)

RESPONSE: The Department agrees, however, the change in reporting will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: In the Appendix under "Immunization," commenters recommend that periodic surveys and audits to determine compliance with immunization requirements contained in N.J.A.C. 8:57-4 be conducted every year instead of every three years. This will be needed to meet or exceed age-appropriate immunization goals stated in "Healthy People 2010" and "Healthy New Jersey." (104 and 105)

RESPONSE: The Department agrees with this suggestion. This change to the rules will be considered in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: Three comments were received about information contained in the Appendix, Section III, Maternal and Child Health Activities, Infants and preschool children. Comment one states, Section III(a)1., "Guidelines for the Child Health Conference," (CHC) does not reflect current practice. CHC service provision stated in the Appendix should reflect "Recommendations for Utilization of Public Health Priority Funding." These recommendations have been approved by the Public Health Council as the appropriate practice for the provision of CHC services. Comment two states concerning, Section III(a)3., "Blanket referral for CHC services without reference to the provision of such services to those individuals not otherwise able to access preventive

health services is not consistent with current principles and practice concerning assisting families to access health insurance and a medical home for comprehensive preventive and primary care services." Comment three states, concerning Section III(a)4., "Provision for information and guidance on physical, emotional, nutritional, and cognitive development of infants and preschool children goes beyond CHCs and home visiting. ... Children under five have been identified as a vulnerable population, and are particularly affected by issues of unintentional injury, nutrition, immunization and access to health care -- among the leading health indicators stated in Healthy People 2010. … In summary, my recommendations for the listing of activities for infant and preschool children are to incorporate, in whole or in part, the activities for child health conferences and child health care consultation as activities currently supported in the utilization of the CY 1999 Public Health Priority Funding (PHPF) applications." (105)

RESPONSE: The Department agrees with these suggestions. It is the Department's intent to make the type of changes suggested by the commenter when the next edition of "Best Practices" are developed. This change to the rules will be achieved in future rulemaking since making this type of change in this final adoption is a substantive change from the notice of proposed rulemaking that was published January 7, 2002.

COMMENT: One commenter stated, "It is recommended that a standard be set that provides for training of Local Health Officers in methods to evaluate performance against goals and to assess program and staff effectiveness." Another commenter stated that, " It is reasonable to conclude that many Local Health Officers will not have the leadership and managerial skills in addition to their general public health knowledge. It is therefore reasonable that practice standards allow better for training and that a standard for professional training and education be specified." (14, 27, 28 and 58)

RESPONSE: The Department agrees with the commenters concerns. N.J.A.C. 8:52-8.4(b)5 states that health officers are required to obtain continuing education contact hours in accordance with N.J.A.C 8:7, Licensure of Persons for Public Health Positions. N.J.A.C 8:7- 1.15(a)(9) requires leadership and management training. The Department will evaluate N.J.A.C. 8:7 and make any appropriate changes in future rulemaking.

COMMENT: Four comments were received regarding N.J.A.C. 8:52-1.7, County environmental health activities (CEHA). Commenters 24 and 28 questioned whether the rule as written shifted CEHA responsibility from the county to the local health agency. Commenter 7 stated, "… CEHA powers should be given back to the local boards of health for compliance. This section should be expanded to include the roles and responsibilities of local boards of health." A representative of the Department of Environmental Protection stated, "… While I support this requirement, I am not sure how it could be enforced. Currently the counties of Mercer and Morris do not participate in the CEHA program, which is a voluntary program." (59)

RESPONSE: In many cases, the same local health agency performs public health and environmental health programs set forth under the Local Public Health Services Act, N.J.S.A. 26:3A2-1 et seq., and the County Environmental Health Act, N.J.S.A. 26:3A2-

21 et seq., respectively. The intent of the language of the rule was to reinforce the dual role of local health agencies. It was not the intent to set rules for environmental health or usurp the authority of the Department of Environmental Protection. Consequently, in order to agree with the voluntary nature of this program as explained by the Department of Environmental Protection (DEP), the Department has changed the wording in N.J.A.C. 8:52-1.7 in the final adoption from "shall comply" to "may comply."

COMMENT: "8:52-2.1 Definition for Health Educator: Change 'educational' to 'education.' Should read: ' Health educator means an individual who is responsible for assessing individual and community health education needs; …'" (106)

RESPONSE: As suggested to correct a typographical error, the word "educational" has been changed to the word "education" in the final rule adoption.

COMMENT: "8:52-2.1 The definition of local public health system should include EMS provider agencies." (7)

RESPONSE: The term, "but are not limited to" indicates that this definition is not all inclusive. The Department has clarified the language to include "emergency medical services" since these entities were inadvertently left off the list and since they provide a critical function in protecting the public health.

COMMENT: "8:52-3.2 (a): Add 'health education services as set forth in N.J.A.C. 8:52-6.' Should read, 'Public Health Services shall include administrative services as set forth in N.J.A.C. 8:52-5, health education services as set forth in N.J.A.C. 8:52-6, public health nursing services as set forth in N.J.A.C. 8:52-7 … " (106)

RESPONSE: As suggested to provide clarity regarding this broad statement of the content of the rule, the wording "health education services as set forth in N.J.A.C. 8:52-6" has been added in the final rule adoption.

COMMENT: " 8:52 -3.2 (a) 8 After the words, 'ensure a competent local public health ' a word needs to be inserted such as 'system.' " (7)

RESPOND: As suggested to correct a typographical error, the word "system" has been added to the final adoption.

COMMENT: The rules should be corrected at N.J.A.C. 8:52-3.1(c), 3.2(a)9iv, 7.2(a)3, and 12.2(a). for grammar and at N.J.A.C. 8:52-6.2(c) 1 through 15, 7.2(b) and 7.2(b)2 for sentence structure so that each item starts with the same form of speech, that is, noun, verb, etc. (107)

RESPONSE: As suggested, the language has been corrected upon adoption at N.J.A.C. 8:52- 3.2(a)9iv, 6.2(c)1 through15, 7.2(b)2 and 12.2(a). Based on the citations and language provided in the comments, the Department was not able to determine the

corrections the commenter believed should have been made to some of the cited provisions; therefore, no further action was taken for N.J.A.C. 8:52-3.1, 7.2(a)3 and 7.2(b).

COMMENT: "8:52-4.1 (a) (3): Should read, 'Health educator as defined in N.J.A.C. 8:52-2." (106)

RESPONSE: As suggested to provide consistency to the document, the wording “as defined at N.J.A.C. 8:52-2” has been added to the words “Health educator” in N.J.A.C. 8:52-4.1(a)(3) in the final adoption.

COMMENT: Four comments were received regarding which organizations accredit schools of nursing, public health and public health education. Commenter 2 recommended that the language "Hold a baccalaureate/ masters degree from an accredited college or university recognized as such by the National League of Nursing" be changed to "Hold a baccalaureate/masters from an organization authorized by the US Department of Education to accredit nursing education programs," since multiple organizations currently accredit nursing education programs. Commenter 18 stated, in N.J.A.C. 8:52-4.2(j)2, “… consideration should be given to accepting a Master of Public Health degree from an institution that is accredited by the Council on Education in Public Health (CEPH) as an additional option to the accreditation cited in the proposed standards.” Commenter 106 stated, “Delete the ‘Commission on Higher Education’ in N.J.A.C. 8:52-4.2 (d) (1), (i) (1) and (k). The correct accreditation agencies for public health education are: the Council on Education for Public Health (CEPH) or the SOPHE/ AAHE Baccalaureate Approval Committee.” Commenter 18 stated, “Consideration should be given in 8:52-4.2 (j) 2 to include a master of public health from an accredited school of public health or program in public health to substitute for one year of experience.”

RESPONSE: The Department's intent in the language of the rule was to consider degrees from all schools that are accredited through a recognized process. Although the commenters cited examples related to nursing, public health and health education, specific agencies that accredit schools and universities appear throughout N.J.A.C. 8:52-4.2,.at (b)1, (d)1, (e)1, (f)1, (g)1. (h)1, (i)1, (j)1 and 2, (k), (l)1 and (m)1. The Department believes that these comments indicate that the rule as written used outdated information and needs to be clarified. Consequently, to clarify the rule, the wording in N.J.A.C. 8:52-4.2 (b)1, (d)1, (e),1, (f)1, (g)1, (h)1, (i)1, (j)1, (k), (l)1 and (m)1 has been amended to read “… from an accredited college or university.” For N.J.A.C. 8:52-4.2 (j)2, the language has been changed to, “master of public health from an accredited school or program in public health may be substituted for one year of experience.”

COMMENT: Commenters 1 and 2 stated that the New Jersey Board of Nursing certifies advanced practice nurses only; thus the word "certified" needs to be removed. It was suggested that the language be changed to: "Holds a current license to practice as a registered professional nurse by the NJ State Board of Nursing."

RESPONSE: The Department agrees that the language in the rule was not intended to include advanced practice nursing. To clarify and correct outdated information so that it agrees with current Board of Nursing terminology, the word "certified" and the citations listed in N.J.A.C. 8:52-4.2(b)2, (h)2, (l)2 and (m)2 will be deleted and the suggested language will be used in the final adoption.

COMMENT: Commenters 1 and 2 suggested expanding the degree types for health educator in N.J.A.C. 8:52–4.2(d) and the director of health education in N.J.A.C. 8:52-4.2 (i), from "health education, community health or related field" to include "nursing and/or public health."

RESPONSE: The language in the final adoption will be clarified to further expand the term "related field" to read "Hold a baccalaureate degree in, including, but not limited to, health education, community health, nursing and/or public health from an accredited college or university." As stated above, the Department has agreed to meet with the appropriate parties representing health education and nursing and report these findings to the Public Health Council. All necessary changes to the rule will be addressed in subsequent rulemaking.

COMMENT: "Consideration should be given to having the public health medical director qualifications be consistent with those required by the New Jersey Board of Medical Examiners (BME) licensure requirements. By having a less stringent requirement in 8:52-4.2 (j) l than the BME, a physician could potentially practice medicine in a local health department for up to six months (8:52-4.2 (j) 3. without being qualified to practice medicine and surgery in New Jersey." (2 and18)

RESPONSE: A review of the "public health medical director" responsibilities as outlined in the rule was conducted to determine if they fell within the definition of the "practice of medicine" in New Jersey. Although it is not anticipated that a primary responsibility of the "public health medical director" will be to treat patients, the evaluation of treatment recommendations is included in the rule definition cited at N.J.A.C. 8:52-2.1. Since the "practice of medicine" as defined by the Board of Medical Examiners is the diagnosis, treatment and/or the development of treatment plans for a patient, it was determined that the "public health medical director" would need to be licensed as a physician in New Jersey. Consequently, the Department agrees that the provision in N.J.A.C. 8:52-4.2(j)3 that allows a medical license from the Board of Medical Examiners within six months of appointment may be problematic since it is less stringent than State licensure requirements.

The six month option was provided in the rule since the pool of candidates for this position was considered limited and it was determined that it would be necessary to have a provision in the rule to allow out of state candidates. To achieve the same goal, the Department determined that it would be more appropriate to phase in this provision as it has done repeatedly throughout the rules when it determined that existing resources had to be reorganized or additional resources needed to be provided. As such, upon adoption, N.J.A.C. 8:8-52-4.1(b)6, the requirement for the medical director, has been amended to

provide a six-month phase-in period to allow candidates to meet the Board of Medical Examiners licensing requirement and N.J.A.C. 8:8-52-4.2(j)3 has been amended to delete the option of obtaining a state medical license within six months of appointment.

COMMENT: Delete "of" and replace with "for," and add “Inc.” in N.J.A.C. 8:52-8.4(b)3 and 4. (106)

RESPONSE: The Department agrees with these changes and has corrected the language in the final adoption.

COMMENT: "8:52-8.4 Workforce Continuing Education, the workforce leadership topics and subjects should say, 'include but not limited to the topics listed as i-x.' I can think of other leadership topics such as Team building, Annual Performance Evaluation …" (34)

RESPONSE: The Department agrees with this suggestion. The language in N.J.A.C. 8:52-8.4(b)1 is amended on adoption from “such as” to “that include but are not limited to” to provide clear language that indicates that the list of topics is not meant to be all inclusive.

COMMENT: Commenter 106 stated, "8:52-8.4 (b) (3) (i-vii): Delete list of leadership courses and replace with list of leadership courses in 8:52-8.4 (b) (1) to make consistent with nursing section above. Should read: Eight of the continuing education hours annually shall be comprised of workforce leadership courses and shall include topics and subjects such as:

i. Strategic thinking and planning;
ii. Policy development, implementation, and evaluation;
iii. Advocacy;
iv. Interpretation of epidemiological data and health statistics analysis;
v. Community needs assessment and risk assessment;
vi. Outcome evaluation and quality assurance;
vii. Collaboration, coalition building, and community organization;
viii. Multidisciplinary negotiation;
ix. Legal matters and issues; and
x. Health education research."

RESPONSE: The Department agrees with this suggestion and, to provide clarity and consistency to the rule, will change the language to that suggested by the commenter. In addition, the language in the final adoption will be changed from “such as” to “that include but are not limited to” to provide clear language that indicates that the list of topics is not meant to be all inclusive.

COMMENT: “At 8:52-10.3 Data collection and management, in subsection (b), the generic term for an immunization registry stated as the Statewide Immunization

Information Systems should be replaced by the current nomenclature which is the New Jersey Immunization Information System (NJIIS)." (104)

RESPONSE: The Department agrees with this suggestion and for clarity will replace the generic term for the immunization registry with the current nomenclature, New Jersey Immunization Information System (NJIIS), in the final adoption.

COMMENT: Two comments were received regarding N.J.A.C. 8:52-12.2. Commenter 58 stated, " … Clarity is required regarding the relationship and relative authority of the local Offices of Emergency Management and Local Health Offices in cases of disaster or emergency. Also not clearly articulated are the related roles at the State level under the same conditions. Written procedures should be disseminated and maintained regarding obtaining state or federal consultation or technical assistance in case of emergencies." Commenter 59 stated, " … I recommend that local health agencies' emergency response activities are incorporated into their county Office of Emergency Management (OEM) Plan, to ensure consistency with the OEM plan and consistency of emergency response activities among all local entities that respond to public health emergencies. Otherwise, local health agencies and Hazmat units could be working off of two different plans, rather than having a coordinated approach to a public health emergency.

RESPONSE: The Department agrees with the commenters. By clarifying the relationship and relative authority of local Offices of Emergency Management (OEM) and Local Health Offices and integrating their plans, the Department will ensure coordination with other systems, other counties and the State. However, this type of change would impact upon the operation of the OEM and this rule has no authority in this area. As stated above, the Department is in the process of hiring 22 planner /coordinators and one of their roles will be to develop integrated public health emergency response plans that integrate other traditional county and local response agencies in a LINCS Agency's area. In addition, the Department will clarify the language in N.J.A.C. 8:52-12.2(b) regarding "assist" to include, "work with the municipal and county OEMs to ensure the coordination and integration of public health and emergency management planning and response activities."

COMMENT: "In the Appendix, Section II. Communicable Disease Activities; Immunization (a) 4., the language should be modified to reflect the most current terminology and federal laws as follows: Utilize vaccine information statement forms and maintain related documentation for individuals receiving state-issued vaccines according to State Directives and in compliance with federal law." (104)

RESPONSE: The Department agrees with this suggestion and for clarity in the final adoption will use the suggested language to reflect current terminology and Federal laws.

COMMENT: In the Appendix, Section III, under "Infants and preschool children," the Child Health Services Report (MCH20) should be changed to "CH-7" to reflect the new title of the report. (105)

RESPONSE: The Department agrees with this suggestion and has verified with the commenter that the name of the form is the same and that only the form number has changed. In addition, the commenter stated that this form is again due for revision and at that time the form number will change again. Consequently, for clarity and to allow for continued revisions of the form, the wording in the final adopted rule will be changed.

**Summary** of Changes Upon Adoption:

The following changes will be made on adoption.

1. N.J.A.C. 8:52-1.7 is amended on adoption in order to agree with the voluntary nature of this program as explained by the Department of Environmental Protection.

2. In order to correct a typographical error, the definition of "health educator" in N.J.A.C. 8:52-2.1 is amended on adoption.

3. The definition of "local public health system" in N.J.A.C. 8:52-2.1 is amended on adoption to include "emergency medical services" to clarify the language since "emergency medical services" were inadvertently left off the list of entities that make up the local public health system.

4. To provide consistency in the rules N.J.A.C. 8:52-3.2(a) is amended on adoption to clarify and add language related to health education that was inadvertently omitted. Consequently, the words "health education services as set forth at N.J.A.C. 8:52-6" have been added.

5. In order to correct a typographical error, N.J.A.C. 8:52 -3.2(a)8 is amended on adoption to add the word "system."

6. N.J.A.C. 8:52-3.2(a)9iv, 6.2(c)1 through 15, 7.2(b)2. and 12.2(a) are amended on adoption to correct grammar or sentence structure.

7. N.J.A.C. 8:52-3.3(a)3 and 7 and 14.1 are amended on adoption to correct the citations. The Department noted that the citations cited as part of the local health agency's minimum capacity in N.J.A.C.8:52-3.3(a)3 and 7 and enforcement of the State sanitary code in N.J.A.C. 8:52-14.1 were not correct since they reflect responsibilities of the State Department of Health and Senior Services (N.J.A.C. 8:8, 8:9 and 8:44) and they do not reflect all the responsibilities of local health agencies (N.J.S.A. 24:14A-1 et seq., 26:3-69.1 and 58:11-23; N.J.A.C. 5:17, 7:9A, 8:21, 8:23A, 8:25 and 10:122). To correct this in the adoption, the Department has deleted the citations in N.J.A.C. 8:52-3.3(a)3 and 7 and 8:52-14.1, that reflect responsibilities of the State Department of Health and Senior Services and added the additional citations as needed.

8. To provide consistency in the rule, N.J.A.C. 8:52-4.1(a)3 is adopted to read "Health educator as defined at N.J.A.C. 8:52-2."

9. In order to correct the language so that it is not less stringent than the Board of Medical Examiners licensure requirement for physicians, N.J.A.C. 8:8-52-4.1(b)6 has been amended on adoption to provide a six-month phase-in period to allow candidates to meet the Board of Medical Examiners licensing requirement and N.J.A.C. 8:8-52-4.2(j)3 has been amended on adoption to delete the option of obtaining a State medical license within six months of appointment .

10. In order to correct and clarify outdated information at N.J.A.C. 8:52-4.2(b)1, (e)1, (f)1, (g)1, (h)1, (j)1 and 2, (k), (l)1, (m)1., so that it does not limit the schools that public health professionals can receive degrees from, these provisions of the rule have been amended to read on adoption "… from an accredited college or university" and N.J.A.C. 8:52-4.2(j)2 has been amended to, "master of public health from an accredited school or program in public health may be substituted for one year of experience."

11. N.J.A.C. 8:52-8:52-4.2(b)2, (h)2, (l)2 and (m)2 are modified on adoption in order to clarify outdated information. The word "certified" and the citations have been deleted to reflect current Board of Nursing terminology.

12. The language in N.J.A.C. 8:52-4.2(d)1 and (i)1 is being amended on adoption to clarify "or related field" as associated with the degree types for health educator and the director of health education.

13. N.J.A.C. 8:52-8.4(b)1 is amended on adoption to clarify the language so that it indicates that the list of leadership topics is not meant to be all inclusive.

14. N.J.A.C. 8:52-8.4(b)3 and 4 are amended on adoption to delete "of" replace with "for," and add "Inc." after "National Commission for Health Education Credentialing."

15. N.J.A.C. 8:52-8.4(b)3 is amended on adoption to provide clarity and consistency to the types of leadership courses public health professionals are to attend.

16. N.J.A.C. 8:52-8.4(c) is amended on adoption to clarify the voluntary nature of this statement.

17. N.J.A. C. 8:52-10.3(a) is amended on adoption to correct a typographical error. The citations are being changed from N. J.A.C. 8:52-5.2(e) and/or (f) to N.J.A.C. 8:52-5.2 (f) and (g).

18. N.J.A.C. 8:52-10.3(b) is amended on adoption for clarity by replacing the generic term for an immunization registry with the specific name for New Jersey's registry.

19. N.J.A.C. 8:52-11.2(h) is modified on adoption to clarify the legal authority of the Department concerning the need for local board of health to obtain approval to provide services not addressed by the Community Health Improvement Plan.

20. N.J.A.C. 8:52-12.2(b) is clarified on adoption by changing the word "assist" to "work with" and specifying the activities expected of local health agencies related to municipal and county Offices of Emergency Management.

21. Appendix, Section II. Communicable Disease Activities, Immunization, subparagraph (a)4, is amended on adoption to reflect the most current terminology and Federal laws.

22. Appendix, Section III. Maternal and Child Health Activities, Infants and preschool children, subparagraph (a)2 is amended on adoption to replace the form number of the Child Health Services Report (MCH20) with the current number, CH-7 and add "or subsequent form number." In addition, references through the proposed rules to their effective date have been changed upon adoption to the actual effective date.

## Federal Standards Statement

The adopted new rules, N.J.A.C. 8:52, are not adopted under the authority of, or in order to implement, comply with, or participate in any program established under Federal law, or under a State statute that exceeds, incorporates or referred to Federal law, Federal standards, or Federal guidelines. Therefore, a Federal standards analysis is not required.

**Full text** of the adoption follows (additions to proposal indicated in boldface with asterisks *** thus ***; deletions from proposal indicated in brackets with asterisks *[ thus ]*):

Chapter 52
Public Health Practices Standards of Performance
for Local Boards of Health in New Jersey

SUBCHAPTER 1. GENERAL PROVISIONS

8:52-1.1 Purpose

(a) The purpose of this chapter is to:

1. Establish standards of performance for public health services that meet the legislative intent as set forth in the Local Health Services Act, N.J.S.A. 26:3A2-1 et seq. and Local Boards of Health, N.J.S.A. 26:3-1 et seq.;
2. Assure the provision of a modern and manageable array of public health services to all citizens of New Jersey;

3. Designate activities which are required by all local boards of health which shall build local public health capacity and encourage the development of an integrated systems approach for local public health;
4. Encourage cooperation among community partners to protect and improve the health of New Jersey residents;
5. Align local boards' of health and local health agency's performance standards with National Public Health Performance Standards and National Model Community Standards as described in "National Public Health Performance Standards Program Local Public Health System Performance Assessment Instrument;"
6. Build a reliable and cost-effective public health system;
7. Protect and promote physical and mental health and prevent disease, injury, and disability, thereby assuring the health of the citizens of New Jersey; and
8. Support the goals of "Healthy New Jersey 2010: A Health Agenda for the First Decade of the New Millennium" to increase the quality and years of life of New Jersey residents and to eliminate health disparities.

8:52-1.2 Scope

Each local board of health shall establish and maintain the standards of performance as set forth in this chapter. No standard shall be construed to authorize a lesser standard than that prescribed by statute or rule or to empower or require a local health agency to act in matters solely under the jurisdiction of a State, county, or municipal government.

8:52-1.3 Compliance

(a) Each local board of health and local health agency shall be accountable for their adherence to standards of performance to the Public Health Council and to the Department pursuant to the provisions of N.J.S.A. 26:3A-2 et seq.

(b) Each local health agency shall make available to the Office of Local Health, within 10 business days of the request, source data and information used for evaluation and determining adherence to standards of performance as set forth at N.J.A.C. 8:52-1.4.

(c) If a local board of health is found to be deficient in meeting the standards of performance as set forth in this chapter, the local board of health shall be required to submit a corrective action plan within 30 calendar days to the Office of Local Health. Regardless of this corrective action plan, the Department may take action at the expense of the non-compliant municipality in accordance with the provisions set forth at N.J.S.A. 26:3A2-11 and 26:2F-13.

8:52-1.4 Performance monitoring and evaluation

A method for evaluation and determining adherence to standards of performance shall be developed by the Office of Local Health as set forth at N.J.A.C. 8:52-16. The information and data may be used by the Office of Local Health for compliance purposes, publication, and research.

8:52-1.5 Registration

(a) Each board of health shall register annually with the Office of Local Health.

(b) Registration information shall be made in a format determined by the Office of Local Health and shall include:

1. Identification of membership of the local board of health;
2. Experience, education and training relevant to public policy development;
3. The type of local governance;
4. The type of authority exercised (governing body, autonomous or advisory);
5. Jurisdictional areas by municipal code;
6. The annual public health budget;
7. A schedule of meetings of the local board of health;
8. Identification of the local health agency and any other providers contracted to deliver public health services; and
9. The names, addresses, telephone numbers, fax numbers, and e-mail addresses of the leadership personnel of the local board of health.

8:52-1.6 Contractual services

A recognized public health activity which meets the standards of performance prescribed in this chapter may be planned and offered directly by the local board of health or by any person or agency under contract to the board, provided that the contract specifies that the services to be provided shall be consistent with the provisions set forth in this chapter and shall not violate any State statute or rule.

8:52-1.7 County environmental heath activities

Each local health agency * [shall ] * * **may** * comply with all applicable provisions of the County Environmental Health Act, N.J.S.A. 26:3A2-21 et seq. and the standards promulgated thereunder by the Department of Environmental Protection, N.J.A.C. 7:1H.

8:52-1.8 Standards and publications referred to in this chapter

(a) The full title, edition, and availability of each of the standards and publications referred to in this chapter are as follows:

1. "National Public Health Performance Standards Program Local Public Health System Performance Assessment Instrument," as amended and supplemented. This document is available through the Public Health Practice Program Office, Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, GA, 30333 or at www.phppo.cdc.gov.

2. "Public Health Practice Standards of Performance for Local Boards of Health, N.J.A.C. 8:52-1 et seq., Programmatic Guidelines for Best Practices" incorporated herein by reference as the Chapter Appendix, and the "Companion Document to Public Health Practice Standards of Performance for Local Boards of Health, N.J.A.C. 8:52-1 et seq." These documents are available from the Office of Local Health, PO Box 360, Trenton, NJ 08625-0360, 1-609-292-4993 or at www.state.nj.us/health/lh/olh.htm.
3. "The Public Health Workforce: An Agenda for the 21st Century," as amended and supplemented. This document is available from the US Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion, 200 Independence Avenue, SW, Room 738G, Washington, DC 20201 or at www.health.gov/phfunctions.
4. The "Core Competencies for Public Health Professionals," Council on Linkages Between Academia and Public Health Practice, as amended and supplemented. This document is available from the Public Health Foundation, 1220 L Street, NW, Suite 350, Washington, D.C. 20005 or at www.trainingfinder.org/competencies.
5. "Assessment Protocol for Excellence in Public Health (APEX-PH) Part 1: Organizational Capacity Assessment," as amended and supplemented. "Mobilizing for Action through Planning and Partnerships" (MAPP) and "Protocol for Assessing Community Excellence in Environmental Health" (PACE EH), as amended and supplemented. These documents are available from National Association of County and City Health Officials, 440 First Street, NW, Suite 500, Washington, DC 20001 or at www.naccho.org.
6. "Healthy New Jersey 2010," as amended and supplemented. This document is available from the Department's Office of Policy and Research, PO Box 360, Trenton, NJ 08625-0360, 1-609-984-6702 or at www.state.nj.us/health/healthy2010.
7. "Health People 2010," as amended and supplemented. This document is available from the U.S. Department of Human Services, 200 Independence Avenue, SW, Washington, DC 20201 or at www.health.gov/healthypeople.

## SUBCHAPTER 2. DEFINITIONS

### 8:52-2.1 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Actively participate" means that the local health officer or his or her designees do not miss more than one regularly scheduled meeting in a 12-month period for meetings which are scheduled monthly or attend 75 percent of all meetings for meetings

held more frequently than one time per month and provide input and take necessary action as required.

"Advocacy" means to act and speak out in support of a specific public health issue or cause.

"Assure" means to achieve agreed upon goals by encouraging the actions of public or private entities, by requiring such actions through ordinance, or by providing direct service.

"Capacity" means the ability to perform services through available resources, staffing, and/or contractual agreements.

"Clinical preventive health services" means those primary care services that assure timely epidemiological investigation and specific disease prevention and containment and are those services which are an integral component of the public health protection and prevention process.

"Community health assessment" means a formal countywide or multi-countywide process which determines the health status and quality of life. The assessment identifies problems, assesses the community's capacity to address health and social service needs, and allows for Statewide comparability. The assessment also identifies those populations, if any, that are under served by providers in that community and provides information about resource distribution and costs.

"Community Health Improvement Plan" means a formal written plan which includes the roles and responsibilities of all participants as well as a mechanism for accountability for agreed upon goals, objectives and services. The plan is developed though a series of timely and meaningful action steps that define and direct the distribution of essential public health services of community public health providers in a specific countywide or multi-countywide area according to partnerships and processes set forth in this chapter. All plans need to be approved by the Office of Local Health.

"Community public health providers" means governmental local health agencies and other public and private entities in the community that provide public health services.

"Competent leadership" means a public health professional who is trained in supervisory and leadership techniques and who has demonstrated an ability to plan, organize, and direct the work of others in order to attain public health objectives.

"Continuous quality improvement" means a process whereby performance is measured on a regular basis, strategies for improving performance are developed and implemented, and feedback monitoring is performed to assure high quality services.

"Data analysis" or "analysis of data" means the collection, compilation, statistical analysis, and interpretation of data.

"Department" means the Department of Health and Senior Services.

"Designee" means one or more licensed public health professional(s) employed by the local health agency who act on behalf of the health officer of that local health agency; or one or more licensed health officer(s) employed by one local health agency who agree to act on behalf of a licensed health officer employed by another local health agency.

"Director of health education" means an individual who is responsible for health education leadership and for the management of the major responsibilities of health education.

"Director of public health nursing" means an individual who is responsible for public health nursing leadership, policy development, planning and quality assurance of public health nursing practice and for the supervision and management of the major responsibilities of public health nursing.

"Distance Learning Network" means a Statewide system of educational facilities which are available and capable of receiving and downlinking satellite transmissions. These facilities also make maximum use of other evolving technologies for the purpose of training public health and other professionals.

"Enforcement" means any action taken by a local board of health or its local health agency to ensure compliance with provisions of N.J.S.A. 26:3-1 et seq., N.J.S.A. 26:3A2-1 et seq., or any other applicable rules promulgated thereunder.

"Epidemiologist" means an individual who is responsible for data instrument design; data analysis; problem solving, development and evaluation of surveillance activities; the design, conduct, and reporting of research projects with the capacity to investigate and describe the determinants and distribution of disease, disability, and other health outcomes; and developing the means for disease prevention and control.

"Field representative, health education" means an individual who performs health education and health promotion activities under the supervision of a health educator.

"Graduate nurse, public health" means an individual who performs direct clinical services under the supervision of a public health nurse.

"Health Alert Network" or "HAN" means the term used by the Federal Centers for Disease Control and Prevention (CDC) to describe the public health infrastructure: the communications system, workforce training and organizational capacity needed to respond to public health emergencies. In New Jersey, the Local Information Network and Communications System (LINCS) and Distance Learning Network form the foundations for the HAN.

"Health education" means any educational, organizational, policy, economic, and environmental intervention designed to stimulate healthy behaviors in individuals, groups, and communities.

"Health educator" means an individual who is responsible for assessing individual and community health education*[al]* needs; planning, implementing, and evaluating effective health education programs; coordinating health education services; serving as a resource person in health education; and communicating health and health education needs, concerns, and resources.

"Health officer" means an individual who is licensed pursuant to N.J.A.C. 8:7 and is employed full-time as the chief executive officer of a municipal, regional, county or contractual health agency. This individual is responsible for evaluating health problems, planning appropriate activities to address these health problems, developing necessary budget procedures to finance these activities, and directing staff to carry out these activities efficiently and economically.

"Information technologist(s)/computer specialist(s)" means an individual who evaluates information technology hardware and/or software, provides technical planning, prepares specifications, evaluates information technology vendors and/or contracts, prepares cost benefit analyses of various information technology solutions.

"Linkages" means a set of formal or informal inter-relationships among organizations and agencies which constitute a community public health system.

"Local Information Network and Communications System" or "LINCS" means a network of public health agencies which are inter-connected with the Department through an electronic public health information system that is built on personal computer and Internet technologies.

"Local board of health" means a county or municipal board of health, or a board of health of any regional, local, or special health district having the authority to regulate public health or sanitation by ordinance.

"Local health agency" means any municipal local health agency, contracting local health agency, regional health commission, or county health department that is administered by a full-time health officer and conducts a public health program pursuant to law.

"Local public health system" means the informational, financial, organizational and human resources that contribute to the public's health. These include, but are not limited to, local health agencies, hospitals, *** emergency medical services ,*** managed care organizations, primary care centers, social services agencies, schools, health care practitioners, church groups, volunteer agencies, and community-based organizations.

"Monitor" means to systematically measure a process or task or to track compliance with standards, guidelines, laws, rules or regulations.

"Office of Local Health" means the Office of Local Health within the Department of Health and Senior Services.

"Policy" means a set of comprehensive public health laws, methods, and guidelines which are based on scientific knowledge.

"Preventive health services" means those population-based activities such as clinical, health education and/or health promotion, screening, treatment, and follow-up which provide primary or secondary disease prevention.

"Public health" means organized societal efforts to protect, promote, and restore the people's health, and societal activities undertaken to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, and counter threats to the health of the public.

"Public health emergencies" means urgent, severe threats to the health of the population which are of an acute nature and require immediate response. Response may include mitigation and enforcement by the local governmental public health system.

"Public health medical director" means an individual under the administrative direction of a health officer of a local health agency who is responsible for developing and evaluating medical policies related to the public's health. These policies include, but are not limited to, evaluation of screening recommendations, treatment recommendations, and the use of medical devices through the performance of core public health functions and the delivery of the "10 essential public health services," at N.J.A.C. 8:52-3.2(a)1 through 10.

"Public health nurse" means an individual who uses knowledge from nursing, social, and public health sciences to promote and protect the health of populations through the performance of core public health functions and the delivery of the "10 essential public health services," at N.J.A.C. 8:52-3.2(a)1 through 10.

"Public health nursing supervisor" means an individual who is responsible for managing the daily public health nursing activities for the performance of core public health functions and the delivery of the 10 essential public health services," at N.J.A.C. 8:52-3.2(a)1 through 10.

"Public health planner" means an individual who is responsible for the collection and summary of relevant health information through the use of modern health planning tools; the use of current techniques in decision analysis; the identification and integration of public health laws, regulations, and policies into specific local health agency programs and activities; the preparation of policy options with expected outcomes and

recommendations for the appropriate course of action; and the development of mechanisms to evaluate the effectiveness and quality of public health programs.

"Registered environmental health specialist" means an individual who is licensed pursuant to N.J.A.C. 8:7 and is responsible for the performance of inspections, the compilation of proper records of inspections, the collection of evidence of violations, and the issuance of notices of violation to responsible parties.

"Surveillance" means the continuous systematic collection, analysis, and interpretation of health data that is essential to planning, implementation, evaluation of public health practice, and dissemination of these data.

"Surveillance system" means a functional capacity for data collection, analysis, and dissemination linked to public health programs, and the application of these data to prevention and control.

SUBCHAPTER 3. PUBLIC HEALTH PRACTICE

8:52-3.1 Practice of public health

(a) The practice of public health in New Jersey is defined by the programs and capacities to provide services as set forth at N.J.A.C. 8:52-3.2(a), below and shall be ensured by each local board of health for each of its residents in accordance with this chapter.

(b) Local health agencies shall be responsible for delivering and ensuring population-based public health services as set forth in this subchapter.

(c) Local boards of health and local health agencies developing a countywide or multi-countywide systems approach to build the capacity and expertise required pursuant to this chapter may do so in accordance with the guidelines found in the "Companion Document to Public Health Practice Standards of Performance for Local Boards of Health, N.J.A.C. 8:52-1 et seq."

8:52-3.2 Services and capacities

(a) Public health services shall include administrative services as set forth at N.J.A.C. 8:52-5, *** health education services as set forth at N.J.A.C. 8:52-6, *** public health nursing services as set forth at N.J.A.C. 8:52-7, and the three core functions of public health which have been expanded to become the "10 essential public health services," in (a)1 through 10 below. Public health services shall:

1. Monitor health status to identify community health problems as set forth at N.J.A.C. 8:52-10. This service includes:
    i. Collecting, compiling, interpreting, reporting, and communicating vital statistics and health status measures of populations or sub-populations, as available, within one or more counties. Reporting shall be contingent upon the development of electronic reporting systems;

ii. Assessing health service needs; and
iii. Timely analyzing, communicating, and publishing information on access to, utilization of, quality of, and outcomes of personal health services;

2. Diagnose and investigate health problems in the community as set forth at N.J.A.C. 8:52-12. This service includes:
   i. Identifying emerging epidemiological health threats;
   ii. Supporting prevention efforts with public health laboratory capabilities;
   iii. Supporting active infectious disease prevention and control efforts; and
   iv. Acquiring and sustaining technical capacity for epidemiological investigation of disease outbreaks and patterns of chronic disease and injury;
3. Inform, educate, and empower people regarding health issues as set forth at N.J.A.C. 8:52-6. This service includes:
   i. Social marketing and targeted public media communications regarding public health issues;
   ii. Providing accessible health information resources at the community level;
   iii. Collaborating with personal health care providers to reinforce health promotion messages and programs; and
   iv. Initiating health education with schools, community groups, special populations, and occupational sites;
4. Mobilize community partnerships to identify and solve health problems as set forth at N.J.A.C. 8:52-9. This service includes:
   i. Convening community groups and associations that have access to populations and resources to facilitate prevention, screening, rehabilitation, and support activities; and
   ii. Identifying and organizing community resources through skilled coalition building to support the goals and activities of a countywide public health system;
5. Develop policies and plans which support individual and community health efforts as set forth at N.J.A.C. 8:52-11. This service includes:
   i. Systematic countywide and state level planning for health improvement;
   ii. Development and tracking of measurable health objectives as a part of a continuous quality improvement strategy;
   iii. Development of consistent policies regarding prevention and treatment services; and
   iv. Development of codes, regulations, and legislation to authorize and guide the practice of public health;
6. Enforce the laws and regulations that protect health and ensure safety as set forth at N.J.A.C. 8:52-14. This service includes:
   i. Enforcement of the State Sanitary Code;

ii. Protection of food and drinking water supplies;
iii. Compliance with environmental health activities regarding air, water, noise, and nuisances; and
iv. Investigation of health hazards, preventable injuries, and exposure-related diseases in both the work and community settings;

7. Link people to needed personal health services and assure health care when it is otherwise unavailable as set forth at N.J.A.C. 8:52-13. This service includes providing:
   i. Access to the personal health care system by socially disadvantaged individuals;
   ii. Culturally and linguistically appropriate materials and staff to assure linkage to services for special populations;
   iii. Continuous care management;
   iv. Transportation services;
   v. Technical assistance and health information for high risk groups; and
   vi. Occupational health programs;
8. Ensure a competent local public health *** system *** and assure a competent personal health care workforce as set forth at N.J.A.C. 8:52-8. This service includes:
   i. Assessing existing and needed competencies at the community and organizational levels pursuant to N.J.A.C. 8:52-4.2;
   ii. Establishing standards for public health professionals;
   iii. Evaluating job performance;
   iv. Requiring continuing education; and
   v. Training management and leadership;
9. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services as set forth at N.J.A.C. 8:52-16. This service includes:
   i. Evaluating the effectiveness, accessibility, and quality of personal and population-based health services;
   ii. Developing objectives and measurements and collecting and analyzing data and information which are used to compare performance with agreed upon standards;
   iii. Determining the success or failure of a program or activity;
   iv. Recommending for improvement, expansion or termination * [of ] * a program or activity; and
10. Research for innovative solutions to health problems as set forth at N.J.A.C. 8:52-15. This service includes:
   i. The continuous linkage between the practice of public health and academic and research institutions;
   ii. The capacity to perform timely epidemiological and economic analyses;

iii. The ability to conduct health services and health practice research; and

iv. The appropriate utilization of research findings.

(b) Competencies for delivering the above referenced "10 essential public health services" shall be those set forth in "The Public Health Workforce: An Agenda for the 21st Century" and the "Core Competencies for Public Health Professionals," incorporated herein by reference, as amended and supplemented. See N.J.A.C. 8:52-1.8(a)3 and 4.

8:52-3.3 Local health agency's minimum capacity

(a) Each local health agency shall, at a minimum, have the capacity to deliver:

1. Basic public health services set forth in "Public Health Practice Standards of Performance for Local Boards of Health, N.J.A.C. 8:52-1 et seq., Programmatic Guidelines for Best Practices" which is attached here as Appendix incorporated herein by reference. Upon completion of the community health assessment and the Community Health Improvement Plan set forth at N.J.A.C. 8:52-10 and 11, services provided shall reflect the priorities identified.
2. Administrative services consistent with N.J.A.C. 8:52-5;
3. Environmental health services that integrate Registered Environmental Health Specialist practice as set forth in the State Sanitary Code (N.J.A.C. *[8:8, 8:9] * * **8:21** *, 8:22, 8:23, ***8:23A,*** 8:24, * **8:25,*** 8:26, 8:27, * [8:44,] * 8:51 * [and 8:57-1 through 4)] * * **, 10:122, 5:17 and 7:9A, and N.J.S.A. 24:14A-1 et seq., 26:3-69.1, and 58:11-23*;**
4. Health education and health promotion services consistent with N.J.A.C. 8:52-6;
   i. This service shall be developed *[within one year of the effective date of this chapter]* **by February 18, 2004*;**
5. Preventive health services, that integrate public health nursing practice and health education and/or health promotion programs, and shall be consistent with N.J.A.C. 8:52-13;
   i. This service shall be developed *[within three years of the effective date of this chapter]* ***by February 18, 2006*;**
6. Public health nursing services consistent with N.J.A.C. 8:52-7;
   i. This service shall be developed *[within one year of the effective date of this chapter]* ***by February 18, 2004*;**
7. All other public health services required by the State Sanitary Code (N.J.A.C. *[8:8, 8:9] * * **8:21** *, 8:22, 8:23, * **8:23A,*** 8:24, * **8:25,*** 8:26, 8:27, * [8:44,] * 8:51 * [and] * *,* 8:57-1 through 4***, 10:122, 5:17, and 7:9A, and N.J.S.A. 24:14A-1 et seq., 26:3-69.1 and 58:11-23***); unless the population or entity requiring the services does not exist within the local health agency's jurisdiction or the services are otherwise assured through formal written linkages with another local health agency.
8. Emergency response services consistent with N.J.A.C. 8:52-12;

9. Enforcement services consistent with N.J.A.C. 8:52-14; and
10. Specialized services consistent with N.J.A.C 8:52-3.4.
    i. This service shall be developed *[within two years of the effective date of this chapter]* ***by February 18, 2005*.**

8:52-3.4 Specialized regional expertise and capacity

(a) Each local health agency, *[within two years of the effective date of this chapter]* **by February 18, 2005*,** shall have access to the following regional expertise and capacities to meet standards of performance:

1. Administrative leadership and planning and coordination to implement all "10 essential public health services" set forth at N.J.A.C. 8:52-3.2(a)1 through 10;
2. Public health community planning and coordination of population-based preventive health services;
3. Coordinated public health nursing services and the administration thereof;
4. Coordinated public health education and health promotion services and the administration thereof;
5. Epidemiological investigations and data analysis;
6. Public health laboratory analyses;
7. Coordinated information technology management;
8. Training and staff development;
9. Coordinated environmental health services;
10. Collection, analysis, and dissemination of health data and information;
11. Application skills for health-related grants;
12. Development of medical policy;
13. Coordinated prevention and control of communicable disease;
14. The conduct of public health and health services research and evaluation studies;
15. Development of public health applications that use the geographical index system (GIS);
16. A technical library consisting of current public health information; and
17. Public health emergency preparedness planning.

SUBCHAPTER 4. PUBLIC HEALTH STAFFING

8:52-4.1 Public health staffing requirements

(a) Each local health agency shall employ a full-time health officer who holds an active license and employ or contract for the services of the following professional staff:

1. Public health nurse(s) as defined at N.J.A.C. 8:52-2;
2. Registered environmental health specialist(s) who holds an active license; and
3. Health educator(s) ***as defined at N.J.A.C. 8:52-2*.

(b) Each local health agency providing specialized regional expertise and capacity pursuant to the provisions set forth at N.J.A.C. 8:52-3.4 shall provide the services of the following professional staff:

1. Epidemiologist(s);
2. Information technologist(s)/computer specialist(s);
3. Public health planner(s);
4. Public health nursing director(s);
5. Director(s) of health education; and
6. Medical director(s) *** by August 18, 2003 ***.

8:52-4.2 Public health staffing qualifications

(a) Each health officer shall be licensed by the Department pursuant to the provisions of Licensure of Persons for Public Health Positions, N.J.A.C. 8:7.

(b) Each public health nurse shall have the following qualifications:

1. Hold a baccalaureate degree *** in nursing *** from an accredited college or university ***** [recognized as such by the National League of Nursing ]*****;
2. Hold a current license to practice as a registered professional nurse * [and who is certified ] * by the New Jersey State Board of Nursing * [in accordance with N.J.A.C. 13:3-7 and N.J.S.A. 45:11-23 et seq.] *;
3. Have a minimum of one year experience in public health or working with a preceptor or local resource person; and
4. Complete a course in population-based public health nursing within one year of employment.

(c) Each registered environmental health specialist shall be licensed by the Department in accordance with the provisions of N.J.A.C. 8:7.

**(d)** Each health educator shall have the following qualifications: **(See note at end of rule regarding this requirement)**

**1.** Hold a baccalaureate degree * [from a college or university accredited as such by the Commission on Higher Education in health education, community health, or a related field] * *** in a related field, including, but not limited to, health education, community health, nursing and/or public health from an accredited college or university*;**
2. Meet national credentialing standards of the profession as a Certified Health Education Specialist. Specifically exempted from this requirement is any individual who holds this position prior to * [the effective date of these rules] * ***February 18, 2003***; and
3. Have a minimum of two years of relevant experience in health education.

(e) Each epidemiologist shall have the following qualifications:

1. Hold either a Master of Science degree from an accredited college or university * [recognized as such by the Commission on Higher Education] * or a Master of Public Health from an accredited college or university * [recognized as such by the Commission on Higher Education] * in epidemiology or biostatistics; and
2. Have a minimum of two years experience working as an epidemiologist in a health-related field.

(f) Each information technologist / computer specialist shall have the following qualifications:

1. Hold a baccalaureate degree from an accredited college or university * [recognized as such by the Commission on Higher Education] *; and
2. Have a minimum of three years experience in computer programming, information systems design, and systems analysis. The experience shall have included responsibility for the development and implementation of a moderate sized server-based local area network of about 20 end users.

(g) Each public health planner shall have the following qualifications:

1. Hold a masters degree from an accredited college or university * [recognized as such by the Commission on Higher Education] * in public heath, business administration, or public administration; and
2. Have a minimum of two years of professional experience in health planning.

(h) Each public health nursing director shall have the following qualifications:

1. Hold a masters degree from an accredited college or university * [recognized as such by the Commission on Higher Education] * in public health, or a masters degree in nursing from * [a]* ***an accredited*** school of nursing * [accredited by the National League for Nursing] *;
2. Hold a current license to practice as a registered professional nurse and who is certified by the New Jersey State Board of Nursing * [in accordance with N.J.A.C. 12:37-7 and N.J.S.A. 45:11-23 et seq.] *; and
3. Have a minimum of five years of supervisory experience in public health.

(i) Each director of health education shall have the following qualifications:

1. Hold a master or baccalaureate degree * [form a college or university accredited as such by the Commission on Higher Education in health education, community health, or a related field] * * **in a related field, including, but not limited to, health**

**education, community health, nursing and/or public health from an accredited college or university*;**

2. Meet national credentialing standards as a Certified Health Education Specialist (CHES). Specifically exempted from this requirement is any individual who holds this position prior to *[the effective date of theses rules]* ***February 18, 2003***; and
3. Have a minimum of two years of relevant experience if master degree trained or five years of relevant experience if baccalaureate degree trained.

(j) Each public health medical director shall have the following qualifications:

1. Hold a Doctor of Medicine or Doctor of Osteopathy from an accredited medical school or school of osteopathy supplemented by at least the first year of post-graduate training (PGY-1);
2. Have a minimum of two years of comprehensive medical experience in private or public health practice or be Board-eligible for one of the certifying boards approved by the American Board of Medical Specialties or one of the certifying boards of the American Osteopathic Association. A Master of Public Health from an accredited *[college or university recognized as such by the Commission on Higher Education] * * **school or program in public health** * may be substituted for one year of experience; and
3. * [Either be] * * **Be** * licensed by the New Jersey Board of Medical Examiners * [or obtain such a license within six months of appointment]* .

(k) Each field representative health education shall hold a baccalaureate degree from an accredited college or university * [recognized as such by the Commission on Higher Education] * in health education, community health, or a related field.

(l) Each graduate nurse, public health shall have the following qualifications:

1. Hold an associate degree in nursing from an accredited college * [recognized as such by National League for Nursing] * or hold a diploma in nursing;
2. Hold a current license to practice as a registered professional nurse * [and who is certified] * by the New Jersey State Board of Nursing * [in accordance with N.J.A.C. 12:37-7 and N.J.S.A. 45:11-23 et seq.] *;
3. Have a minimum of one year experience in public health or working with a preceptor or local resource person; and
4. Have successfully completed a course in population-based public health nursing within one year of employment.

(m) Each public health nursing supervisor shall have the following qualifications:

1. Hold a baccalaureate degree in nursing from an accredited college or university *[recognized as such by the National League for Nursing] *;
2. Hold a current license to practice as a registered professional nurse * [and who is certified] * by the New Jersey State Board of Nursing * [in accordance with N.J.A.C. 13:3-7 and N.J.S.A. 45:11-23 et seq.]* ; and
3. Have a minimum of three years of experience as a public health nurse.

## SUBCHAPTER 5. ADMINISTRATIVE SERVICES

### 8:52-5.1 Scope and purpose

This subchapter addresses all of the administrative and organizational management services which are necessary to effectively lead a modern local health agency. The functions of management and leadership include, but are not limited to, planning, organization, public health staffing, coordination and response, budgeting, and evaluation and reporting.

### 8:52-5.2 Management and leadership

(a) Planning is one of the fundamental responsibilities of a licensed health officer who functions as the chief executive officer of a local health agency. Planning relies on the ability to collect and analyze information to communicate with superiors, peers and subordinates and to make decisions and take action. The "Assessment Protocol for Excellence in Public Health" (see N.J.A.C. 8:52-1.8(a)5) is a management tool developed to assist the public health manager in evaluating his or her own agency's strengths and weaknesses. Using this information, the manager is equipped to accurately portray the capabilities his or her agency brings to a countywide public health system and to take actions that will improve the agency's performance.

1. Each health officer shall actively participate in and be responsible for the joint development of a countywide or multi-countywide Community Health Profile, Community Health Assessment and Community Health Improvement.
2. Each health officer shall notify the Office of Local Health of the name, title, telephone number, and e-mail address of his or her designees.
3. Each health officer shall be responsible for the completion of an evaluation of the capacity of his or her local health agency in accordance with the process set forth in "Assessment Protocol for Excellence in Public Health." The evaluation shall be used to identify the capacity of the local health agency to deliver the services set forth in this chapter and to provide the information

necessary to develop the Community Health Improvement Plan. An evaluation shall be conducted at least once every three years.

4. Each health officer shall be responsible for the development of goals and objectives for each program conducted by the local health agency and the development of a continuous quality improvement process to ensure progress in achieving the local health agency's goals.
    i. Each goal and objective shall include a timeline and be realistic, measurable, and consistent with current public health practice and/or Department program policies and guidelines.
    ii. Each goal and objective shall be consistent with priority public health problems identified through the countywide Community Health Improvement Plan and any other statewide public health priorities as determined by the Department.
    iii. Each goal and objective shall be consistent with the "10 essential public health services," at N.J.A.C. 8:52-3.2(a)1 through 10.
5. Each health officer shall develop an internal monitoring plan that measures progress in achieving each of the local health agency's goals and objectives.
    i. Monitoring shall be performed, at a minimum, on a semi-annual basis; and
    ii. Monitoring data shall be used to document whether expected objectives are achieved to provide information regarding the implementation of objectives, and to modify activities to improve the achievement of objectives.
6. Each health officer shall develop an improvement plan to address performance deficiencies which are revealed during the Continuous Quality Improvement process.

(b) The ability to organize information and resources is also a fundamental responsibility of an administrative manager. The ability to assess staff competencies and to match those competencies with the appropriate tasks and activities is key to agency performance and goal attainment. A competent manager must be able to determine lines of authority within his or her agency and set forth business practices that are appropriate to the capabilities of the organization.

1. Each health officer shall ensure that the local health agency's resources are organized to promote the health outcomes identified through the countywide or multi-countywide Community Health Improvement Plan.
2. Each health officer shall ensure that competent leadership is assigned responsibility for each major activity and core responsibility.

3. Each health officer shall ensure that the local health agency prepares and has on file a current table of organization which depicts reporting relationships within the local health agency.

(c) The practice of public health, like the practice of medicine fro which it derives, relies heavily upon licensure and certification to assure quality services and to protect the public against the services of untrained or incompetent individuals. The practice of medicine literally puts individual people's lives in the hands of the physician. The practice of public health puts the lives and quality of life of populations and communities in the hands of public health professionals. Therefore, it is important that these professionals are also trained and licensed in the disciplines of health science and public health. In addition, it is important for a manager to recruit, retain and develop his/her staff. The publications referenced below provide an organized approach to building staff competencies and developing staff.

1. Each health officer shall ensure that all professional public health staff who require licensure, certification, or authorization to perform their activities shall be currently licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey or under the applicable standards of the appropriate body.
2. Each health officer shall ensure that all public health staff receive adequate training for the activities they are expected to perform. Training shall be in accordance with the professional licensing requirements and/or state and/or national standards for each public health program. Each health officer shall determine that professional public health staff have obtained continuing education in accordance with the provisions set forth at N.J.A.C. 8:52-8.
   i. A plan for staff knowledge and competency development shall be developed and shall meet the standards described in "Assessment Protocol for Excellence in Public Health," incorporated herein by reference, as amended and supplemented. See N.J.A.C. 8:52-1.8(a)5.
   ii. Staff competencies shall meet the standards described in "The Public Health Workforce: An Agenda for the 21st Century" and the "Core Competencies for Public Health Professionals." See N.J.A.C. 8:52-1.8(a)3 and 4.
3. Each health officer shall ensure that all professional public health staff who require licensure, certification, or authorization to perform their activities shall perform within the scope of their license, certificate, or authority as set forth under the appropriate laws or rules of the State of New Jersey or under the applicable standards of the appropriate body.
4. Each local board of health shall ensure that its local health agency and health officer meet all of the requirements of this chapter.

(d) Each health officer shall ensure appropriate coordination and response to

public health problems that follow established scientific guidelines within his or her area of jurisdiction as directed and/or coordinated by the Department.

(e) Each health officer shall have access to a financial officer for assistance in managing and overseeing all public health budgets. The financial officer shall assist in ensuring the fiscal integrity of public health finances and that such procedures are in accordance with professionally accepted standards of accounting and auditing.

(f) The ability for a manager to evaluate his or her staff and agency performance is essential to assuring success in meeting the agency's mission and goals. Evaluation is also essential for assuring the prudent use of precious resources and for maximizing cost benefits. Reporting the results of evaluation processes and other important information is a key communication responsibility. Communication is a critical ingredient for success and a public health administrative manager must have the skills to communicate effectively to superiors, subordinates, professional peers and the public.

1. Each health officer shall report local board of health performance data as required in the Local Health Evaluation Report.
2. The Local Health Evaluation Report shall be completed annually and in accordance with the format developed and promulgated by the Office of Local Health. It shall be filed with the Office of Local Health no later than February 15 of the year succeeding the year for which the performance is being reported.
3. The following information shall be reported and shall conform to the reporting schedule set forth herein and shall include:
    i. Registration of the local board of health pursuant to N.J.A.C. 8:52-1.5;
    ii. Information and data regarding a local health agency's capacity as set forth at N.J.A.C. 8:52-3.3 and 5.2(a), above;
    iii. Information and data regarding specialized regional expertise and capacity as set forth at N.J.A.C. 8:52-3.4;
    iv. Information regarding workforce assessment as set forth at N.J.A.C. 8:52-8.2(a);
    v. Training of each local board of health member as set forth at N.J.A.C. 8:52-8.2(b);
    vi. Evaluation of each community's public health partnerships effectiveness as set forth at N.J.A.C. 8:52-9.2(d);
    vii. County Health Status Indicators Report as set forth at N.J.A.C. 8:52-10.2(c) and (e);
    viii. Community health planning information as set forth at N.J.A.C. 8:52-11;
    ix. Community Health Improvement Plan as set forth at N.J.A.C. 8:52-11.2(f)4; and

x. Epidemiological, economic, and health services research findings as set forth at N.J.A.C. 8:52-15.

4. Each local health agency shall report all diseases, threats, and emergencies in accordance with all applicable State and Federal laws as set forth at N.J.A.C. 8:52-5.2(f)3.

(g) Rapid advances in communication technologies are making it possible to be more knowledgeable and current in the practice of public health. The practice of public health relies on scientific capabilities to study, investigate and understand the determinants of health. Based upon an organized scientific collection and analysis of data and information, preventive strategies are developed and communicated to the populations at risk. Modern public health practitioners must be able to use electronic tools and become integrated in an evolving state health information network that will allow them access to real time information upon which to take appropriate actions.

1. Each local health agency shall be part of a Statewide public health information and communication system. This shall include maintaining a link via the Internet with the New Jersey Local Information Network and Communications System (LINCS).

2. Each local health agency shall participate in information sharing and data interchange with the Department.

3. Each local health agency shall use LINCS to:

i. Report all diseases and threats to the public health to the Department in accordance with applicable State and Federal laws, rules, and regulations. Electronic reporting shall be contingent upon the development of electronic reporting systems;

ii. Immediately report to the Department all emergencies that threaten the health or safety of the citizens in its jurisdiction; and

iii. Monitor LINCS e-mail twice per day, at the beginning and at the end of the workday.

(h) Each local health agency shall have access to an attorney licensed to practice in New Jersey for assistance in interpreting, developing, and/or guiding the enforcement of public health laws, rules, regulations, and ordinances.

(i) Records which are required by this chapter shall be maintained in accordance with State record retention standards as promulgated by the New Jersey Department of Education, Bureau of Archives and History, at N.J.A.C. 15:3-3.8.

8:52-5.3 Community public health activities

(a) Each local board of health shall ensure that there is a mechanism that provides leadership to develop partnerships with community organizations

and/or agencies which have a demonstrable affect on, or compelling interest in, the health status of the population in accordance with N.J.A.C. 8:52-9.2.

(b) Each health officer shall conduct an annual public meeting to report the status of the community's health and how it compares with corresponding objectives set forth in "Healthy New Jersey 2010," or its Federal equivalent, and with objectives from the Community Health Improvement Plan. The meeting shall also include a discussion of the local health agency's progress and performance in accomplishing its mission and achieving its objectives.

8:52-5.4 Public health system assurance

(a) Each health officer shall actively participate in countywide or multi-countywide meetings to assess the health status of the population, to develop a Community Health Improvement Plan, and to determine his or her local health agency's roles and responsibilities within the Plan in accordance with N.J.A.C. 8:52-9, 10, and 11.

(b) Each local board of health shall ensure representation in the planning process to develop the Community Health Improvement Plan as set forth at N.J.A.C. 8:52-9.2.

(c) Each local board of health shall ensure the development of local policies and programs that are consistent with the Community Health Improvement Plan as set forth at N.J.A.C. 8:52-11.2.

## SUBCHAPTER 6. HEALTH EDUCATION AND HEALTH PROMOTION

8:52-6.1 Scope and purpose

This subchapter addresses the strategies that promote health and quality of life. This service includes any combination of health education and related activities which are designed to facilitate behavioral and environmental adaptations to protect or improve health. This process enables individuals and communities to control and improve their health status. This service also provides opportunities for individuals to identify problems, develop solutions, and work in partnerships which build on existing skills and strengths.

8:52-6.2 Health education and health promotion services

(a) Each local health agency shall provide a comprehensive health education and health promotion program which is developed and overseen by a health educator and provides integrated support to the daily operation of the local health agency.

(b) Each local health agency shall implement and evaluate culturally and linguistically appropriate population-based health education and health promotion activities that are developed in accordance with the Community Health Improvement Plan.

(c) Each local health agency shall ensure that health education and health promotion services provide the core public health functions and the delivery of the "10 essential health services" at N.J.A.C. 8:52-3.2(a)1 through 10 that shall include, but not be limited to:

1. Assessment and analysis of individual and community needs and assets;
2. Planning of theory-based health education programs which includes the development of appropriate and measurable objectives;
3. Implementation of population-based health education programs which match various educational strategies and methods to the identified issues. Strategies may include, but are not limited to, direct programming, train-the-trainer programs, community organization methods, media campaigns, and advocacy initiatives;
4. ***[**Process]* ***Provision of process***, impact, and outcome evaluation of health education programs in order to measure achievement and success;
5. Management of health education programs, personnel, and budgets;
6. Development of in-service training programs for staff, volunteers, and other interested parties;
7. * [Volunteer recruitment] * ***Recruitment*** and training ***of volunteers*** to build and support community coalitions and partnerships;
8. Identification of and facilitation among agencies and community resources to reduce duplication and enhance services;
9. *[Client]* ***Provision of client*** referral and assistance to health and social service resources;
10. Development of risk communication plans to manage community concern and convey appropriate and accurate information;
11. * [Advising and/or serving ] * ***Advise and/or serve*** as a spokesperson and liaison to the media;
12. *[Public]* ***Provision of public*** health advocacy for policies and funding that support social justice principles and which will improve the health status of communities;
13. * [Grant ] ***Provision of grant*** writing to support local health agency objectives, the Community Health Improvement Plan, and health education programs;
14. Development of audio, visual, and print materials which support program initiatives; and
15. Use of quantitative and qualitative research techniques to advance the quality of public health practice.

(d) Each local health agency shall plan and develop health education programs and interventions regarding the uninsured, underinsured,

immigrant, indigent, and other vulnerable populations within its jurisdiction.

(e) Each local health agency shall inventory health promotion and health education services delivered by all agencies in their jurisdiction. This inventory shall compare the existing services with those outlined in the Community Health Improvement Plan in order to identify gaps, reduce duplication, and to identify opportunities for collaborative partnerships.

## SUBCHAPTER 7. PUBLIC HEALTH NURSING

### 8:52-7.1 Scope and purpose

This subchapter addresses the synthesis of nursing practice and public health practice for the purpose of protecting and promoting physical and mental health and preventing disease, injury, and disability. Public health nursing practice incorporates the core public health functions of assessment, assurance, and policy development within the art and science of professional nursing practice through a systematic process which promotes and protects the public health.

### 8:52-7.2 Public health nursing services

(a) Each local health agency shall provide comprehensive public health nursing services that provide integrated support to the daily operation of the local health agency.

(b) Each local health agency shall ensure that public health nursing practice provides the core public health functions and the delivery of the "10 essential public health services" as set forth at N.J.A.C. 8:52-3.2(a)1 through 10. These services shall be developed and overseen by a public health nurse and shall include, but not be limited to:

1. Assessing and identifying populations at risk;
2. * [Outreach ] * * **Providing outreach** * and case finding using population-based services;
3. Using systematic, relevant data collection from public health nursing practice for community health assessment;
4. Using case information and epidemiological methods to link epidemiology and a clinical understanding of health and illness;
5. Developing and implementing health guidance, counseling, and educational plans using the established nursing process;
6. Providing health plans to assure health promotion efforts that include primary clinical prevention and early intervention strategies;
7. Using the nursing process and triage to determine priorities for interventions and services based on risk assessment and community needs especially for underserved populations;
8. Advocating policies and funding that create clinical programs and improve health status;
9. Establishing procedures and processes which ensure competent implementation of prevention measures and treatment schedules;

10. Providing clinical preventive services, including clinical screenings and preventive care;
11. Facilitating access to care through the use of nursing assessment, referral for risk reduction, prevention, restorative, and rehabilitative services, and the establishing clinical programs and services;
12. Participating in all components of communicable disease prevention and control, including clinical surveillance, case identification, and treatment;
13. Planning, developing, and initiating interdisciplinary nursing plans for care and case management;
14. Establishing and maintaining written procedures and protocols for clinical care; and
15. Identifying, defining, coordinating, and evaluating enhanced clinical services for complex populations and special risk groups.

(c) Each local health agency shall ensure planning and developing public health nursing programs and interventions related to the uninsured, underinsured, immigrant, indigent, and other vulnerable populations.

(d) Each local health agency shall ensure the coordination of public health nursing services which are delivered by all agencies in their county as described in the Community Health Improvement Plan so as to identify gaps, provide continuity of services, and reduce duplication.

## SUBCHAPTER 8. ASSURE WORKFORCE COMPETENCIES

### 8:52-8.1 Scope and purpose

This subchapter addresses the assessment of existing and needed workforce competencies as set forth at N.J.A.C. 8:52-5.2(d) for each local health agency. These include standards for public health professionals, job performance evaluation, continuing education, and management and leadership training.

### 8:52-8.2 Workforce assessment

(a) Each health officer shall ensure the performance of a workforce assessment at the local health agency at least once each year. The workforce assessment shall:
1. Identify gaps in workforce expertise;
2. Identify duplication of workforce competencies; and
3. Ensure that the necessary workforce competencies exist in order to be able to deliver the services set forth at N.J.A.C. 8:52-3.3 and 3.4 and to achieve the objectives outlined in the Community Health Improvement Plan.

(b) Each local board of health shall report the status of training of each local board of health member in their jurisdiction to the Office of Local Health. This report shall be made annually.

8:52-8.3 Workforce standards

(a) Each health officer shall ensure that:

1. Each position in the local health agency has a written job description which include tasks, reporting relationships, and performance standards;
2. Each job description shall be reviewed annually; and
3. Job performance evaluations are conducted annually.

(b) Each local board of health shall ensure that public health staff, in addition to the requirements for licensure, certification, or authorization, possess or are actively pursuing training for the skills necessary to provide each of the "10 essential public health services" as set forth at N.J.A.C. 8:52-3.2(a)1 through 10.

8:52-8.4 Workforce continuing education

(a) Each health officer shall provide a coordinated program of continuing education for staff which includes attendance at seminars, workshops, conferences, in-service training, and/or formal courses to improve employee skills and knowledge in accordance with their professional needs.

(b) Each public health professional specified at N.J.A.C. 8:52-4.1 shall meet continuing education requirements as follows:

1. Each director of public health nursing and public health nursing supervisor shall complete 15 continuing education contact hours of public health-related instruction annually. Eight of the continuing education contact hours shall be comprised of workforce leadership courses. The courses of instruction shall be approved by the Office of Local Health or its authorized representative. The eight continuing education contact hours in workforce leadership shall include topics and subjects *[such as]* ***that include but are not limited to ***:
   i. Strategic thinking and planning;
   ii. Policy development, implementation, and evaluation;
   iii. Advocacy;
   iv. Interpretation of epidemiological data and health statistics analysis;
   v. Community needs assessment and risk assessment;
   vi. Outcome evaluation and quality assurance;
   vii. Collaboration, coalition building, and community organization;
   viii. Multidisciplinary negotiation;
   ix. Legal matters and issues; and
   x. Nursing research.
2. Each public health nurse shall complete 15 continuing education contact hours of public health related instruction annually. The programs shall be approved by the New Jersey State Nurses

Association or its authorized representative or by the New Jersey Association of Public Health Nurse Administrators, Inc.

3. Each director of health education and each health educator shall complete continuing education in accordance with the requirements of the National Commission * [of ] * * **for** * Health Education Credentialing, * **Inc.*** that is, CHES certification. Eight of the continuing education contact hours annually shall be comprised of workforce leadership courses and shall include topics and subjects *[such as]* * **that include, but are not limited to** *:

*[ i. Community partnerships;
ii. Organizing and coalition building;
iii. Use of data and information technologies in policy
iv. development and decision making;
v. Continuous quality improvement;
vi. Cultural diversity;
vii. Integration of health delivery systems; and
viii. Outcomes measurement and evaluation.]*

* **i. Strategic thinking and planning;**
**ii. Policy development, implementation, and evaluation;**
**iii. Advocacy;**
**iv. Interpretation of epidemiological data and health statistics analysis;**
**v. Community needs assessment and risk assessment;**
**vi. Outcome evaluation and quality assurance;**
**vii. Collaboration, coalition building, and community organization;**
**viii. Multidisciplinary negotiation;**
**ix. Legal matters and issues; and**
**x. Health education research. ***

4. Each field representative, health education shall complete a minimum of nine continuing education contact hours annually in courses which are approved by the National Commission * [of ] * * **for** * Health Education Credentialing, * **Inc.,*** New Jersey Society for Public Health Education, or the Office of Local Health.

5. Each health officer and each registered environmental health specialist shall obtain continuing education contact hours in accordance with N.J.A.C. 8:7. Each health officer shall also obtain leadership continuing education contact hours in accordance with N.J.A.C. 8:7.

(c) Each member of a local board of health * [shall] * * **may** * participate in a leadership orientation and participate in on-going training courses**.**

(d) Each health officer shall ensure that all employees are provided the opportunity to participate in distance learning as one method of obtaining continuing education.

(e) Each health officer shall ensure supervisory and managerial competency through leadership training and staff development.

8:52-8.5 Workforce diversity training

Each health officer shall ensure that all employees participate in cultural diversity training.

## SUBCHAPTER 9. COMMUNITY PUBLIC HEALTH PARTNERSHIPS

8:52-9.1 Scope and purpose

This subchapter addresses how entities that impact the public health and have access to populations and/or resources in performing defined prevention, screening, rehabilitation, or support activities will convene, build coalitions, and identify and organize community resources to support the goals and activities of the local public health system.

8:52-9.2 Development and participation in community public health partnerships

(a) Each countywide or multi-countywide area shall establish a community public health partnership representing key corporate, private, and non-profit entities. Each partnership shall perform a countywide or multi-countywide community health assessment in accordance with N.J.A.C. 8:52-10 and develop a Community Health Improvement Plan in accordance with N.J.A.C. 8:52-11. Each community public health partnership shall foster relationships that impact the community's health consistent with the needs identified in the Community Health Improvement Plan. Existing community public health partnerships shall be permitted to satisfy these requirements if they comply with the assessment methodologies set forth at N.J.A.C. 8:52-10.2.

(b) Each local health agency shall:

1. Actively participate in a new or existing community health partnership; and
2. Assure that the community health partnership assesses public health needs and delivers public health services in their jurisdiction.

(c) Each local health agency shall assure that the partnership:

1. Participates in the community health assessment and the Community Health Improvement Plan pursuant to N.J.A.C. 8:52-10 and 11;
2. Develops and maintains linkages among the member partners as described in (a) above;
3. Assumes a leadership role in addressing priority public health issues;
4. Leverages community resources;
5. Provides support programs for the under served;
6. Provides preventive screening and rehabilitative services;
7. Continually reviews input and feedback from the entities that contribute to or benefit from improved community health status;

8. Holds regularly scheduled meetings;
9. Identifies the strategic issues of each local health agency and the means by which the issues can be addressed;
10. Coordinates applicable aspects and priorities with contiguous counties;
11. Develops and maintains relationships with other local health agencies to educate and inform local policy officials, key health providers, and the public of the content of the Community Health Improvement Plan; and
12. Develops a formal mechanism to evaluate the effectiveness of the partnership.
    i. Pursuant to N.J.A.C. 8:52-3.1(c), local health agencies may submit this information in a joint report which encompasses a countywide or multi-countywide area.

8:52-9.3 Other community partnerships

Each local health agency shall meet regularly with representatives of health-related organizations within its jurisdiction in order to coordinate roles and responsibilities for health service delivery.

8:52-9.4 Developing service directories

Each local health agency shall assure that the community public health partnership develops, maintains, and promotes a directory of health service providers and resources that serves the countywide or multi-countywide area. The directory shall address the health priorities as identified in the Community Health Improvement Plan.

SUBCHAPTER 10. MONITOR HEALTH STATUS

8:52-10.1 Scope and purpose

This subchapter addresses the collection, compilation, interpretation, and communication of vital statistics and health status measures within one or more New Jersey counties; the identification of threats to health; the assessment of health service needs; and the analyses, communication, and publication of information on access, utilization, quality, and outcomes of personal health issues.

8:52-10.2 Community health assessment

(a) To minimize costs and for consistency with existing data, the minimum unit of analysis for New Jersey shall be the county. This does not preclude any municipality from performing its own less formal assessment in addition to participating in the countywide or multi-countywide Community Health Assessment. This less formal assessment can be integrated into the countywide or multi-countywide assessment and/or used for other local public health programming purposes.

(b) A formal countywide or multi-countywide Community Health Assessment shall be performed and continually evaluated with a formal update every

four years. Existing community health assessments meeting the criteria set forth in this section shall be valid until a new assessment is performed.

(c) Local health agencies shall submit a description of the Community Health Assessment process and the timeframe for its completion to the Office of Local Health for review and approval prior to initiating the assessment. This process description shall be submitted to the Office of Local Health *[within one year of the effective date of this chapter]* *by February 18, 2004* and every fours years thereafter.

i. Local health agencies working in partnership may submit this information in a joint report for the entire countywide or multi-countywide area.

(d) The formal countywide or multi-countywide Community Health Assessment shall be conducted in accordance with standardized methodologies approved by the Office of Local Health. Such methodologies include "Mobilizing for Action through Planning and Partnerships" (MAPP). The Community Health Assessment shall include, but not be limited to, the following elements:

1. A copy of any existing community health assessments;
2. An evaluation of funding sources;
3. A review of public health community partnership organizations and agencies and their roles;
4. An identification of barriers to transportation, language, culture, and service delivery within the countywide or multi-countywide area that affect access to health services, especially for low income and minority populations;
5. A Community Health Profile which includes measures of health status indicators and socio-demographic characteristics as specified by the Office of Local Health;
6. Current information on the health resources of and the services provided by each entity located within easy access of its population;
7. An assessment of the use of the health resources described in 6, above;
8. Current information on risk factors affecting the population served; and
9. An analysis of health status indicators for the population served in comparison with overall State and national rates for indicators set forth in "Healthy New Jersey 2010."

(e) The results of the countywide or multi-countywide Community Health Assessment shall be published in a "County Health Status Indicators Report." The results shall be presented in a manner that is sensitive and appropriate to individual, family, and community needs, language, and culture. The Report shall contain:

1. Measures of the health status indicators;
2. A description of the process used to complete the Community Health Assessment;

3. The standards with which the health status indicators are compared;
4. An inventory of public health capacities; and
5. An analysis of gaps in public health service.

8:52-10.3 Data collection and management

(a) Each local health agency shall develop, operate, and ensure a quality data management system. This system shall be capable of collecting, analyzing, and monitoring baseline data standardized to a format developed by the Department in accordance with the requirements set forth at N.J.A.C. 8:52-5.2 * [(e) and/or] * (f) *** and (g) ***.

(b) Each local health agency shall ensure electronic linkage with local and Statewide databases, as they become available. These databases include, but are not limited to: NJ LINCS, * [ Statewide Immunization Information System] * ***New Jersey Immunization Information System (NJIIS) ***, Communicable Diseases Reporting Systems, Electronic Birth Registry, Vital Statistics, and other registries which track the distribution of diseases, injuries, and health conditions.

(c) Each local health agency shall ensure safeguards for the confidentiality of all data and information that contains personal identifiers or any other information which could be used to identify an individual with reasonable accuracy, either directly or by reference to other readily available information.

SUBCHAPTER 11. POLICY DEVELOPMENT

8:52-11.1 Scope and purpose

This subchapter addresses the systematic countywide or multi-countywide and state level planning process for health improvement. It sets forth the development and tracking of measurable health objectives as a part of continuous quality improvement strategy, the development of consistent policy regarding prevention and treatment services, and the development of model codes to guide the practice of public health.

8:52-11.2 Countywide or multi-countywide community health planning

(a) To minimize costs and for consistency with existing data, the minimum unit of planning for New Jersey shall be the county.

(b) Each local board of health shall assure that public health policies promote and support the population's health and safety goals identified in the health improvement strategies that were developed through the countywide or multi-countywide Community Health Improvement Plan and incorporate by reference prior planning information obtained through other processes.

(c) Each Community Health Improvement Plan shall consist of:

1. A countywide or multi-countywide Community Health Assessment as described at N.J.A.C. 8:52-10.2;

2. A Community Health Profile as described at N.J.A.C. 8:52-10.2(d)5;
3. A mechanism which monitors external environment for forces and trends that might impact the ability of a local public health system to protect the health of the public;
4. An analysis and a prioritization of current and potential health problems based upon planning methodologies such as those described at N.J.A.C. 8:52-10.2(d);
5. A plan which specifies the roles and responsibilities agreed upon by each local health agency and each public, private, non-profit, and voluntary agency;
6. Specific strategies to address health problems and to sustain effective interventions;
7. A plan to evaluate the intervention strategies and health outcomes; and
8. A method that allows for changes to the plan.

(d) The objectives of the Community Health Improvement Plan shall be:
1. To link State and local services;
2. To mobilize and coordinate a variety of health and social service providers;
3. To improve each local public health system's capacity to respond to public health needs; and
4. To include all providers of public health services, that is, local health agencies, schools, Medicaid managed care providers, environmental health agencies, community-based groups, business and industry and nursing agencies.

(e) Each local health agency within the countywide or multi-countywide area shall be responsible for implementation of the Community Health Improvement Plan in their jurisdiction [within four years of the effective date of this chapter]* *by February 18, 2007*.

(f) Each local board of health shall ensure that there is a mechanism to guide the development of the Community Health Improvement Plan which includes, but is not limited to:
1. Ensuring expertise to implement the planning process;
2. Ensuring coordination and consistency with State policy initiatives;
3. Ensuring that local health agency resources are continuously aligned with their defined roles and responsibilities in the Community Health Improvement Plan; and
4. Reporting the content of the Community Health Improvement Plan to the Office of Local Health. Local health agencies working in partnership may submit this information in a joint report for the entire countywide or multi-countywide area.

(g) Each Community Health Improvement Plan shall be used to guide the development of needed public health programs and services. CHIP shall foster coordination with existing programs and services, and reduce or

eliminate programs and services which are not needed or have been found to be ineffective.

(h) Each local board of health that demonstrates a * [compelling] * local need for public health services, as defined in "Healthy People 2010," that is not addressed by the Community Health Improvement Plan shall address that need. * [ Each local board of health shall demonstrate this need in writing to the Office of Local Health ] *.

SUBCHAPTER 12. DIAGNOSIS AND INVESTIGATION OF HEALTH PROBLEMS AND HAZARDS

8:52-12.1 Scope and purpose

This subchapter addresses the epidemiological identification of emerging health threats; public health laboratory capability to support prevention efforts; active infectious disease prevention and control efforts; and technical capacity for epidemiological investigation of disease outbreaks and patterns of chronic disease and injury.

8:52-12.2 Emergency response capability

(a) Each local health agency shall ensure * [their ] * * **its** * capacity to immediately respond to a public health emergency in accordance with applicable state and federal requirements. Each local health agency shall also:

1. Maintain a mechanism which allows for emergency communication 24 hours per day, seven days per week, including weekends and holidays;
2. Develop a preparedness plan with the local public health system to address public health emergencies. The plan shall be consistent with and be integrated with the Health Alert Network; and
3. Orient and train their staff (through exercises) to their roles and responsibilities under the plan at least annually.

(b) Each local health agency shall * [assist] * * **work with** * their municipal and county Office of Emergency Management * [by providing public health resources, scientific leadership, and other support in order to ensure appropriate public health response for its jurisdiction] * * **to ensure the coordination and integration of public health and emergency management planning and response activities** *.

8:52-12.3 Surveillance

(a) Each local health agency shall collect data and information pursuant to N.J.A.C. 8:52-5.2(e).

(b) Each local health agency shall ensure that valid and reliable surveillance systems are in place to monitor the occurrence of diseases and indicators of health. The indicators shall be in accordance with "Healthy New Jersey 2010," the health objectives developed through the Community Health

Improvement Plan, and for health conditions determined to be priorities by the Department.

(c) Each local health agency shall investigate the cause of illnesses or health threatening conditions and shall implement control measures to prevent the spread of disease or to address the known risk factors in the population served.

(d) Each local health agency shall ensure that there is a mechanism to receive reports and to respond to immediately reportable communicable diseases and conditions in accordance with N.J.A.C. 8:57-1.3. This mechanism shall be capable of operating 24 hours per day, seven days per week, including weekends and holidays.

8:52-12.4 Technical capacities

(a) Each local health agency shall ensure access to public health laboratory analyses in order to support disease control and environmental health activities within its jurisdiction.

1. Designated laboratories shall meet all State and Federal requirements for technical competency and safety in accordance with the Federal Clinical Laboratory Improvement Amendment of 1988, Final Rule at 42 C.F.R. 493 and Clinical Laboratory Services. N.J.A.C. 8:44, and N.J.A.C. 8:45.
2. Designated laboratories shall be licensed by the Department pursuant to the provisions of P.L. 1975, c.166, N.J.S.A. 45:9-42.26 et seq. and regularly participate in quality assurance programs offered through the Department.

(b) Each local health agency shall ensure access to epidemiological services that support countywide or multi-countywide assessment, planning, surveillance, and prevention activities in accordance with the provisions set forth at N.J.A.C. 8:52-3.4.

## SUBCHAPTER 13. PREVENTIVE PERSONAL HEALTH SERVICES AND ACCESS TO HEALTH CARE

8:52-13.1 Scope and purpose

This subchapter addresses the accessibility of the personal health care system to socially disadvantaged individuals. Culturally and linguistically appropriate materials and staff shall be accessible to assure linkage to services for special populations. This subchapter also addresses continuous care management, transportation services, and technical assistance and health information for high risk groups as well as occupational health programs.

8:52-13.2 Assure personal and clinical preventive health care

(a) Each local health agency, through the Community Health Improvement Plan, shall:

1. Assess the barriers to personal health care and public health services within its jurisdiction;

2. Define a minimum set of clinical preventive health services, including disease prevention and health promotion, which shall be directed to specific populations. These services shall include, but not be limited to:
    i. Health care and epidemiological follow-up for individuals infected with the human immunodeficiency virus or suffering from acquired immune deficiency syndrome;
    ii. Health care and epidemiological follow-up for individuals having sexually transmitted disease;
    iii. Health care and epidemiological follow-up for individuals having tuberculosis; and
    iv. Adult and childhood immunizations.
3. Develop a plan that provides primary health care services to populations that do not have access to the health care system;
4. Participate in the development of a plan for the early detection of chronic and life threatening diseases in the most vulnerable populations;
5. Assist the local public health system in facilitating access and entry for populations having barriers to personal health care; and
6. Assist the local public health system in assuring personal health care services and clinical preventive health services that are culturally and linguistically appropriate.

8:52-13.3 Community outreach for public health services

(a) Each local health agency shall engage in community outreach activities that:
1. Assure the maximum participation of eligible residents in state- and federally-funded health care programs, including, but not limited to, New Jersey FamilyCare and Medicaid;
2. Assure culturally and linguistically appropriate resources and health informational materials for specific populations as specified in this chapter;
3. Assure technical assistance to employers who conduct health promotion, disease prevention, or injury prevention programs;
4. Assure that there is an active referral system between the mental and/or behavioral health delivery system and the personal health care delivery system; and
5. Assure that social services are coordinated with health care services.

8:52-13.4 Information systems for personal health and related services

Each local health agency shall assist the local public health system and the state in developing capacities for information systems that share client information with managed care organizations, hospitals, and other health care providers.

SUBCHAPTER 14. ENFORCEMENT OF PUBLIC HEALTH LAWS

8:52-14.1 Scope and purpose

This subchapter addresses the enforcement of the State Sanitary Code N.J.A.C. *[8:8, 8:9] * * **8:21 *,** 8:22, 8:23, * **8:23A,*** 8:24, * **8:25**,* 8:26, 8:27, * [8:44,] * 8:51 * [and] * *,*8:57-1 through 4*, **10:122, 5:17 and 7:9A, N.J.S.A. 24:14A-1 et seq., 26:3-69.1 and 58:11-23*)**; the protection of food and potable water supplies; environmental health activities related to air, water, noise, and public health nuisances and health hazards, preventable injuries, and exposure-related diseases in both the workplace and community settings.

8:52-14.2 Public health laws and rules

(a) Each local board of health shall ensure the enforcement of the provisions of the State Sanitary Code.

(b) Each local board of health and each local health agency shall maintain and be knowledgeable regarding current public health laws, regulations, codes, and ordinances and shall ensure enforcement thereof.

(c) Each local health agency shall employ licensed personnel consistent with the provisions set forth at N.J.S.A. 26:3-19 to enforce State and local public health laws, regulations, codes, and ordinances and shall:

1. Maintain written procedures for enforcement actions;
2. Collect evidence of non-compliance; and
3. Maintain documentation of all legal proceedings.

(d) Each local board of health shall consult with the health officer during the development of any new public health ordinances or amendments to any existing public health ordinances. The health officer or his or her designee shall attend all public hearings held which proposes new or amended ordinances that affect the practice of public health within his or her jurisdiction.

(e) Each local health agency shall ensure training for all professional staff assigned public health regulatory enforcement responsibilities. This training shall include, but not be limited to:

1. The purpose of public health law;
2. Activities and techniques for evaluating compliance with the law;
3. Activities and techniques for gathering evidence of violations of public health law;
4. Documenting violations; and
5. Proper methods of testifying at a trial or hearing.

SUBCHAPTER 15. HEALTH RELATED RESEARCH

8:52-15.1 Scope and purpose

This subchapter addresses the continuous linkage between the practice of public health with academic and research institutions; the capacity to perform timely epidemiolgical and economic analyses; the ability to conduct public health and health practice research; and the appropriate use of research findings.

8:52-15.2 Capacity to initiate timely epidemiological, economic, and health services research

(a) Each local health agency shall assure its capacity to conduct:
1. Studies of epidemiological data of identified health problems;
2. Analyses of the economic components of public health issues;
3. Analyses of health services management; and
4. Analyses of the effectiveness of public health practices, programs, and services.

(b) Each local health agency shall report epidemiological, economic, and health services research findings to the Office of Local Health whenever such findings are available.

(c) Each local health agency shall make all data and information available to public health researchers only in accordance with Institutional Review Board requirements as set forth at 45 C.F.R. Part 46 and/or 21 C.F.R. 50 and 56.

(d) Each local health agency shall ensure the safety and protection of public and personal health data and information through established procedures for access, retention, and destruction in accordance with applicable state and federal laws, rules, and codes.

(e) In order to assure the capacity required at N.J.A.C. 8:52-15.2(a), each local health agency is encouraged to form partnerships and share services in accordance with the "Companion Document to Public Health Practice Standards of Performance for Local Boards of Health, N.J.A.C. 8:52-1, et seq.".

8:52-15.3 Operational implementation of research findings

(a) Each local health agency shall assist the local public health system in identifying new public health problems and in developing best practices for new and existing problems.

(b) Each local health agency, in coordination with the Office of Local Health, shall ensure the implementation, on a priority basis, of newly developed and innovative strategies, methodologies, programs, and projects which have been demonstrated to be effective in improving the public health.

(c) All research findings shall be implemented in accordance with the Community Health Improvement Plan.

8:52-15.4 Linkage with institutions of higher education

(a) Each local health agency is encouraged to provide the opportunity for joint appointments for its staff to institutions of higher education.

(b) Each local health agency is encouraged to provide field training or work-study experiences for students enrolled in institutions of higher education.

(c) Each local health agency is encouraged to partner with an institution of higher education to conduct health-related research.

## SUBCHAPTER 16. EVALUATION

8:52-16.1 Scope and purpose

This subchapter addresses the evaluation of the effectiveness, accessibility, and quality of population-based health services; the development of objectives and measurements and the collection and analysis of data and information which are used to compare performance with agreed upon standards; the determination of the success or failure of any program activity; and recommendations for the improvement or the termination of any activity or program.

8:52-16.2 Evaluation and performance

(a) The Office of Local Health shall develop a data collection method which shall benchmark adherence to standards of performance for local boards of health and local health agencies. This benchmark shall be consistent with the provisions set forth in this chapter and shall use a continuous quality improvement process to improve the performance of local boards of health and local health agencies.

(b) As part of the benchmarking process, the Office of Local Health shall develop a standard format for Local Health Evaluation Reports. This report is a tool which shall be used to evaluate and measure local boards of health and local health agencies adherence to standards of performance.

(c) The Local Health Evaluation Report shall be used by each local health agency to:

1. Evaluate annual performance;
2. Provide information and data to improve future performance;
3. Report performance and evaluation data and information to the local boards of health within its jurisdictions; and
4. Foster other purposes determined appropriate by the local health agency and/or the Office of Local Health.

(d) Each local health agency shall submit their Local Health Evaluation Report to the Office of Local Health as specified at N.J.A.C. 8:52-5.2(f).

## APPENDIX
## PROGRAMMATIC GUIDELINES FOR BEST PRACTICES

### I. Environmental Health Activities

### Recreational bathing

(a) The local board of health shall:

1. Conduct a sanitation and safety program at public bathing places (that is, swimming pools, lakes, rivers and ocean bathing places), based upon the current "Recreational Bathing" regulations contained in the State Sanitary Code (see N.J.A.C. 8:26);

2. Inspect, using an inspection form designed by the Department of Health and Senior Services, each public bathing place at least twice during the operating

season, make follow-up inspections when deficiencies are found, and take necessary enforcement actions;

3. Assure sanitary surveys of natural bathing areas as indicated by bacterial counts and/or epidemiological evidence;

4. Inspect public spas and/or whirlpools at least yearly in accordance with the provisions of the Recreational Bathing regulations (N.J.A.C. 8:26); and

5. Conduct investigations within 24 hours of all deaths and serious injuries and report such occurrences as outlined in the Recreational Bathing Regulations (N.J.A.C. 8:26) on a form developed by the Department of Health and Senior Services.

**Campgrounds**

(a) The local board of health shall:

1. Conduct a sanitation and safety program for campgrounds based upon State law and Chapter II of the State Sanitary Code (N.J.A.C. 8:22-1); and

2. Inspect each campground at least annually to insure compliance; conduct follow-up inspections and initiate enforcement action as necessary.

**Youth Camps**

(a) The local board of health shall conduct a youth camp sanitation and safety program (N.J.A.C. 8:25) and shall:

1. Inspect each youth camp once prior to opening; and

2. Perform necessary follow-up inspections at the request of Consumer and Environmental Health Services; and

3. Submit copies of each inspection to Consumer and Environmental Health Services, Department of Health and Senior Services.

**Food surveillance**

(a) The local board of health shall maintain surveillance of retail food establishments, food and beverage vending machines and shall:

1. Conduct a retail food establishment program based upon State laws and regulations, including Chapter 12 of the State Sanitary Code and local ordinances, if applicable (N.J.A.C. 8:24);

2. Inspect retail food establishments using forms approved by the Department of Health and Senior Services at least once a year, inspect vending machines dispensing potentially hazardous foods at least once a year and those dispensing non-potentially hazardous foods on a complaint basis or as required by local ordinance;

3. Initiate appropriate enforcement action to secure compliance with State law and local ordinance; collect and prepare evidence for legal action; follow a protocol for taking appropriate enforcement actions to secure compliance (such as abatement letters, administrative hearings, summons, court actions and condemnations);

4. Maintain food establishment and vending machines files at the local health agency office containing inspection reports, food sample reports, and reports of enforcement actions taken and other pertinent data associated with the program;

5. Provide for, or conduct training courses for food service supervisors using curricula approved by the Department of Health and Senior Services such as the Food Manager's Certification Program;

6. Collect samples and provide for laboratory analyses of any food suspected of being associated with a foodborne illness or, as necessary, any food suspected of being adulterated, misbranded or unwholesome;

7. Embargo all food known or suspected of being adulterated, misbranded, unwholesome or associated with foodborne illness within the meaning of local ordinance or State law.

8. Assist the Department of Health and Senior Services upon request in conducting recalls and recall effectiveness checks of foods found to be contaminated, adulterated or misbranded; and

9. Condemn and supervise the destruction or otherwise dispose of food which is adulterated, misbranded, unwholesome or associated with foodborne illness within the provisions of local ordinance or State law.

**Occupational health (operative January 1, 1989)**

(a) The local board of health shall conduct an occupational health program operative January 1, 1989; and shall;

1. Maintain a comprehensive profile of all employers operating in the local jurisdiction. This profile should utilize Department of Labor and Right to Know data filed (see N.J.A.C. 8:59) and include for each employer:

Name of company,
Address of company,
Number of employees,

Major product or service,
Right to Know Data-DEP/DHSS
History of emergency calls,
History of complaints;

2. Maintain a list of occupational health resources and make appropriate referrals in response to requests for information or complaints;

3. Train at least one staff person in Occupational Health and Industrial Hygiene through a continuing education program;

4. Conduct preliminary surveys in workplaces in response to reported occupational diseases or referrals from the Department of Health and Senior Services, using standardized forms provided by the Department of Health and Senior Services to record observations and collect information. (These standardized forms shall be forwarded to the Department of Health and Senior Services' Occupational Health Services for follow-up).

**Public health nuisances**

(a) The local board of health shall conduct a public health nuisance program to include the following:

1. Investigations of public health nuisances including but not limited to noxious weeds, housing, solid waste and insect and rodents, which shall be conducted in accordance with applicable State laws and local ordinances, which are at least equivalent to the "Weed Control Code of New Jersey", the "Solid Waste Code of New Jersey", and the "Public Health Nuisance Code of New Jersey" (which are model codes available from the Department of Health and Senior Services);

2. Conduct complaint investigations and surveys to identify nuisances, and through appropriate follow-up, ensure abatement in accordance with State law and local ordinances;

3. Maintain and make available educational information on the prevention and abatement of public health nuisances; and

4. Maintain current files on all public health nuisances which shall include the investigation, follow-up, abatement and enforcement action taken in each instance.

## II. Communicable Disease Activities

**Reportable diseases**

(a) The local board of health shall conduct a program for the surveillance, investigation and control of reportable diseases and shall:

1. Document episodes of reportable diseases including occupational diseases and/or incidents and transmit the information to the State and other agencies as required by Chapter Two, Reportable Diseases (N.J.A.C. 8:57-1) of the State Sanitary Code and N.J.S.A. 26:4;

2. Conduct prompt investigations of reportable illnesses as well as unusual manifestations of disease not listed as reportable in Chapter 2 of the State Sanitary Code (N.J.S.A. 8:57-1) and institute appropriate control measures and promptly report all findings to the Department of Health and Senior Services;

3. Disseminate and exchange information relative to outbreaks of disease with physicians, hospitals, boards of education, and other responsible health agencies as appropriate; and

4. Analyze reported data to provide a basis upon which to plan and evaluate an effective program for the prevention and control of infectious diseases.

**Immunization**

(a) The local board of health shall promote immunizations for protection against childhood vaccine-preventable diseases and shall:

1. Promote and provide primary and booster immunizations to preschool and school age children for protection against diseases in accordance with current recommendations of the Department of Health and Senior Services;

2. Assist all schools, with an emphasis on preschool facilities, in implementing and enforcing the immunization requirements contained in Chapter 14, of the State Sanitary Code (N.J.A.C. 8:57-4) by providing immunization services and conducting periodic surveys and representative record audits every three years;

3. Secure prompt reporting of vaccine-preventable disease as required by Chapter Two of the State Sanitary Code (N.J.A.C. 8:57-1.2); and

**4.** *[Maintain important information forms (consent forms) for individuals receiving State-issued vaccines according to State directives. ]* *** Utilize vaccine information statement forms and maintain related documentation for individuals receiving State-issued vaccines according to State Directives and in compliance with Federal law.***

. . .

(a) The local board of health shall conduct a program for the control of rabies and other zoonotic diseases and shall:

1. Enforce the rabies vaccination and dog licensing statutory provisions (N.J.S.A. 4:19-15 et seq.), rules for rabies immunizations (N.J.A.C. 8:23A-4), encourage cat vaccination, encourage passage of cat licensing ordinances and conduct State-sponsored free municipal rabies vaccination clinics at least once annually;

2. Ensure that a canvas of all dogs owned or harbored within each municipality is conducted annually or biennially and a report of number of unlicensed dogs is received by the local health department by September 1st of each year and forwarded to the Department, as required by N.J.S.A. 4:19-15.15;

3. Inspect kennels, pet shops, shelters and pounds, annually or more often if necessary to ensure compliance with the regulations for sanitary operation of animal facilities (N.J.A.C. 8:23A-1 et seq.) and ensure that licenses issued to these facilities are in compliance with N.J.S.A.. 4:19-15.8 through 9;

4. Receive reports of animal bites as indicated in N.J.S.A. 26:4-79 through 81, investigate to ensure that persons bitten receive medical care, and confine and observe biting domestic animals for clinical signs of rabies at an impounding facility or other suitable location as indicated in N.J.S.A. 26:4-82;

5. Ensure that rabies specimens from animals with clinical signs of rabies, as diagnosed by a veterinarian, or domestic animals that have died or been euthanized within 10 days after biting a person are delivered immediately to the Department's Public Health and Environmental Laboratories for rabies examination;

6. Ensure that municipalities provide an animal control program that includes the following elements: a licensed impoundment facility where all animals are held, evaluation that the impoundment facility is in full compliance with N.J.A.C. 8:23-1 et seq. and has adequate space for the amount of animals impounded, all persons picking up and impounding animals are certified animal control officers, and there is adequate response to animal control complaints 24 hours/day, 7 days/week;

**Tuberculosis control**

(a) The local board of health shall control the transmission of tuberculosis and shall:

1. Ensure that all of the tuberculosis control services or service elements listed in the "Components of a Tuberculosis Program in New Jersey" (available from the Department's Tuberculosis Program) are available and

accessible to all persons living within the jurisdiction of the local health agency;

2. Ensure prompt reporting of suspected and diagnosed cases of tuberculosis and transmit reports as required by the State Sanitary Code (N.J.A.C. 8:57-1.4 and 1.5);

3. Ensure effective treatment and on-going medical supervision of suspect and diagnosed cases of tuberculosis in accordance with the Centers for Disease Control and Prevention and the American Thoracic Society Guidelines available from the Department's Tuberculosis Program;

4. Ensure that contacts are identified and brought to examination, diagnostic conclusion, and treatment in accordance with the policy of the Standards of Practice for conducting TB Case/Suspect Interviews and Contact Investigation;

5. Ensure the provision of treatment for latent tuberculosis infection in accordance with the Centers for Disease Control and Prevention and the American Thoracic Society guidelines available from the Department's Tuberculosis Program;

6. Ensure reporting of the current status of diagnosed cases of tuberculosis in accordance with the policy of the Department of Health and Senior Services using forms provided by the State;

7. Ensure that all school students, teachers, employees and volunteers and other individuals with TB infection at high risk of developing TB disease and referred to local chest clinics with TB infection, receive appropriate diagnostic evaluation and treatment on a timely basis in accordance with the Centers for Disease Control and Prevention and the American Thoracic Society guidelines available from the Department's Tuberculosis Program;

8. Analyze reported data to provide a basis upon which to plan and evaluate an effective program for prevention and control of tuberculosis;

9. Ensure that the Health Officer in the area of jurisdiction, implements the rules for the Confinement of Persons with Tuberculosis as stipulated in N.J.A.C. 8:57-5.1 through 5.16; and

10. Ensure that the Department's TB Program is notified immediately of all individuals with multi-drug resistant TB in the Health Officer's area of jurisdiction.

**Sexually transmitted diseases**

(a) The local board of health shall control sexually transmitted diseases and shall:

1. Provide for medical services for all persons seeking medical care for Sexually Transmitted Disease (STD);

2. Secure prompt reporting of any case of STD and forward reports immediately to the Department of Health and Senior Services, Communicable Disease Field Program, as required by Chapter Two of the State Sanitary Code (N.J.A.C. 8:57-1.2);

3. Provide interview and investigation services to priority STD cases in accordance with the policy established by the Department of Health and Senior Services and report results of these services on appropriate forms provided by the Department;

4. Provide counseling to all patients infected with STD and treated at public health department STD clinics, to include but not be limited to, disease prevention, sex partner referral, need for follow-up testing, and appropriate action to take when symptoms appear;

5. Provide public education services to the community or target population; and

6. Analyze reported data and provide a basis upon which to plan and evaluate an effective program for the prevention and control of sexually transmitted diseases.

**Human Immunodeficiency Virus (HIV) infection**

(a) The local board of health shall administer a planned program to prevent and control HIV infection and shall:

1. Utilizing seroprevalence and case reporting data provided by the Department of Health and Senior Services, identify ways to reach persons at high risk within the community and develop and implement a strategy to disseminate HIV prevention and control information to these groups;

2. Maintain supplies of educational materials to meet information requests on the transmission, prevention and control of HIV;

3. Provide or arrange for other suitable local health education resources (for example, Planned Parenthood, Red Cross) to conduct education programs addressing the epidemiology, prevention and control of HIV to civic and community organizations and occupationally at risk groups utilizing state prepared or equivalent curricula;

4. Provide or arrange for in-service training addressing the epidemiology, prevention and control of HIV to all local health department personnel;

5. Develop and implement a protocol to refer individuals concerned about their HIV status to counseling and testing sites and other health care providers;

6. Refer HIV infected persons and their families seeking services to appropriate provider agencies such as mental health, drug treatment and other social service agencies; and

7. Participate in the planning, development and implementation of a county or regional program to control HIV infection and the progression to AIDS.

## III. Maternal and Child Health Activities

### Infants and preschool children

(a) The local board of health shall provide health supervision for infants and preschool children and shall:

1. Provide child health conferences for comprehensive preventive health care of infants and preschool children who are uninsured and medically indigent, based upon the current Department's guidelines;

2. Prepare a *Child Health Service Report* [(MCH20) ]* *** CH-7 or subsequent form number*** for each session, and submit promptly on at least a monthly basis to the Department's Maternal and Child Health Program;

3. Maintain an informational and outreach service to encourage physicians, hospitals and social agencies to refer families to the child health conference, women, infants and children supplemental Food Program (WIC) and the public health nursing agency; and,

4. Provide for information and guidance on physical, emotional, nutritional, and cognitive development of infants and preschool children through child health conferences and home nursing visits.

### Childhood lead poisoning

(a) The local board of health shall provide for the prevention and control of lead poisoning in young children and shall:

1. Conduct a program in conformance with N.J.S.A. 24:14A-1 et seq. and Chapter XIII of the State Sanitary Code (N.J.A.C. 8:51-7.7), the major components of which shall include:

i. Case surveillance;
ii. Medical management;
iii. Environmental surveillance;
iv. Education;
v. Use of current versions of "Preventing Lead Poisoning in Children, a statement by the Centers for Disease Control" and findings of the New Jersey Physician Task Force on Lead Poisoning as appropriate.

2. Develop a program plan based on elements in (a)1 above and on the degree of risk in the community as identified through the "Community Health Profile" and "Community Hazard Score for Lead Poisoning in Children" issued by the Department of Health and Senior Services;

3. Conduct case finding efforts among children one through five years of age by annual blood testing in accordance with approved collection techniques in such settings as child health conferences, WIC clinics, day care centers, nursery schools and door-to-door in high risk neighborhoods, with testing priority given to children at higher risk including:

i. Those one through three years of age;
ii. Those residing in or frequenting housing units or other sites where lead-based paint may be present;
iii. Those whose parents or other household members may be occupationally or otherwise exposed to lead sources;
iv. Those at increased risk of exposure to lead sources for whatever reason;
v. Those with a history of pica or increased lead absorption; and
vi. Those who are siblings of a child with increased lead absorption;

4. Assure that a confirmed positive test results based on current risk classification standards is immediately referred to medical supervision and that a child so referred shall receive on-going, medical management as appropriate;

5. Conduct environmental surveillance among patient cases identified, and

i. Provide staff capable of conducting environmental investigations;
ii. Assure that, simultaneous with referral for medical attention, an environmental investigation will be initiated to identify the probable source(s) of lead exposure and to ensure the expedient and safe removal of the lead hazard(s);
iii. Assure that along with the owner of the property wherein the child resides, the parent or guardian of the child shall be notified in writing

and kept abreast as to the findings of the environmental investigation and subsequent surveillance;

iv. Ensure that during periods when actual renovation work is underway, the affected child or children are removed from the premises; and

6. Provide a program of education directed toward parents, the general public, physicians and other health personnel regarding lead intoxication, sources of lead in the environment and control measures; and

i. Assure the provision of appropriate counseling and instruction to parents of lead intoxicated children and to parents of children at risk by trained professional personnel; and

ii. Assure the provision of adequate in-service training and continuing education of program personnel.

**Improved pregnancy outcome**

(a) The local board of health shall reduce infant mortality by improving access to prenatal care and related services in accordance with guidelines established by the Department of Health and Senior Services and shall:

1. Maintain an information and referral system for those requesting family planning, or prenatal and WIC services, to include:

i. A file of all providers of such services in the jurisdiction; and

ii. An active referral file:

2. Maintain a liaison with prenatal clinic services, family planning clinics, WIC school nurses, school health educators, and others;

3. Provide public health nursing services as requested by agencies for prenatal follow-up to high risk women who are determined to be medically indigent, to include, at a minimum:

i. Pregnancy counseling;

ii. Prenatal information;

iii. Follow-up of all referred positive pregnancy tests to promote initiation of prenatal care in the first trimester as requested by agencies;

iv. Nursing support and education through prenatal and postpartum home nursing visits as needed; and

v. Referrals as appropriate to WIC or other nutrition services, social services, and family planning services;

4. Establish and maintain a community outreach and education program targeting high risk women including adolescents to encourage and facilitate early entrance into prenatal care; and

5. Cooperate with the Department of Health and Senior Services, Newborn Biochemical Screening Program to locate and secure repeat specimens from infants when the sample cannot be obtained through the normal channels of a hospital and/or physician.

## IV. Adult Health Services Activities

### 8:52-6.1 Cancer services

(a) The local board of health shall provide cancer prevention for populations at high risk according to criteria outlined in the Department of Health and Senior Services' publication "Adult Health Services Guidelines" and as identified through the Community Health Profile and shall:

1. Establish a coordinated plan for counseling, referral and follow-up of all persons with non-negative screening results;

2. Provide screening services yearly for three percent of women ages 15 to 34 and the three percent of women ages 35 to 64 who are at high risk for cervical cancer;

3. Provide education services yearly for five percent of women ages 15 to 34 and five percent of women 35 and older to receive instruction in these particular areas;

   i. The risk factors for cervical cancer and breast cancer;
   ii. The importance of the Pap Smear in the early detection of cervical cancer (in accordance with the American Cancer Society Guidelines on cervical cancer screening);
   iii. The importance of comprehensive breast cancer screening which include mammography at intervals specified by the American Cancer Society Guidelines and a physical breast examination by a health care professional;
   iv. Breast self examination as one component in a total health care awareness program; and
   v. Dietary and lifestyle modification to reduce the risks of breast and cervical cancer.

4. Provide yearly instruction to three percent of individuals over age 40 in these particular areas:

   i. The risk factors for colon/rectal cancer;
   ii. The importance of compliance with the guidelines on colon/rectal cancer prescribed in Department of Health and Senior Services' Adult Health Services Guidelines; and

iii. The dietary and lifestyle modification to reduce the risk of colon/rectal cancer.

5. Provide annual reports to the State on the demographic characteristics of populations receiving screening and/or education services and the results of these screening programs;

6. Serve as a community resource to disseminate information available from the state on types of screening services available;

7. Provide for cancer-related continuing education for nursing and other program personnel at least once every three years. Include current cancer-related information in the orientation of all newly-hired cancer program staff to be involved in Cancer Services; and

8. Offer smoking prevention and cessation programs as defined in the "Adult Health Services Guidelines" (N.J.A.C. 8:52-6).

**Diabetes services**

(a) The local board of health shall provide for diabetes education services per the Department of Health and Senior Services' "Adult Health Services Guidelines" and shall:

1. Conduct public education related to diabetes and its risk factors such as age, obesity and family history;

2. Conduct diabetes risk assessment on all adult clients who utilize clinical or hypertension or cancer screening services, and counsel, refer, and follow-up clients where appropriate;

3. Educate or appropriately refer known diabetics to available diabetes-related education and other community resources (such as ophthalmologist, podiatrist, etc.); and

4. Provide for diabetes-related continuing education for nursing and other program staff at least once every three years, and include current diabetes-related information in the orientation of all newly-hired staff to be involved in Diabetes Services.

**Cardiovascular disease services**

(a) The local board of health shall provide cardiovascular disease control services according to the Department of Health and Senior Services "Adult Health Services Guidelines" and shall:

1. Provide hypertension screening services yearly to one percent of the high risk population;

2. Provide cardiovascular risk factor assessment and counseling on all individuals screened for hypertension and include the following areas:

   i. Family history of cardiovascular disease;
   ii. Smoking;
   iii. Excessive cholesterol intake;
   iv. Obesity;
   v. Diabetes; and
   vi. Exercise, and counsel, refer and follow-up clients where appropriate.

3. Provide cardiovascular health education programs for the general public;

4. Provide cardiovascular health education programs for hypertensive individuals; and

5. Provide for cardiovascular-related continuing education for nursing and other program staff at least once every three years, and include current cardiovascular-related information in the orientation of all newly-hired staff to be involved in cardiovascular disease services.

**Health services for older adults**

(a) The local board of health shall provide for a health program at locations selected by the health department which identifies the health needs of adults age 65 and older, and shall:

1. Provide a health needs assessment yearly on one percent of the non-institutionalized elderly;

2. Provide education on alcohol abuse and medication management;

3. Follow-up and make referrals as appropriate for abnormal screening results or for needs identified in the individual's history and/or intake;

4. Assure participation at service sites through advance notification (for example: publicity);

5. Provide for gerontology related continuing education for staff at least once every three years, and include current gerontology related information in the orientation program for all new staff providing these services; and

6. Provide immunizations (for example; influenza and pneumococcal vaccines) at the discretion of the local health agency in accordance with the Immunization Practices Advisory Committee on Immunization Practices.

## V. Health Education/Health Promotion

(a) A structured program shall be provided by the Health Educator or Field Representative, Health Education, in accordance with community health education needs, which shall include health components for Alcohol Abuse Control, Drug Abuse Control, Smoking Prevention and Cessation, Nutrition, Injury Control, and Physical Fitness and Exercise and shall include the following:

1. An assessment of health education needs and identification of target population based on information from the New Jersey Department of Health and Senior Services Community Health Profile and other relevant health related data;
2. Written health education program plans with measurable objectives for the six components in (a) above, based on the Health Promotion Guidelines, contained in the Adult Health Services Guidelines and other identified health education needs;

3. Identification and involvement of local leadership in the planning, implementation, and maintenance of needed health education services and programs to include collaboration with other agencies serving the community where such opportunities exist, and consultation with content specialists in the six required components in (a) above; and other areas as needed;

4. Application of appropriate health education interventions to provide for the effective implementation of health education programs (i.e., community development, skill development, simulation, peer group discussion, behavior modification, lecture, media awareness, programmed learning, individual instruction, etc.);

5. Integration of a health education component into health department programs and services, covering the six required promotion topics in (a) above;

6. Consultation and training in the application of health education techniques for the professional staff of the health department;

7. Evaluation and report of the degree of success in achieving predetermined health education objectives; and

8. The health educator or Field Representative, Health Education shall serve as a community health information resource.

**Public health nursing**

(a) Provision of public health nursing services shall include the following:

1. The services of a public health nurse director or supervisor to assess, plan, implement and evaluate public health nursing services in accordance with community health needs;

2. Up-to-date written objectives, policies and procedures developed in cooperation with the health officer, for each activity in which there is nursing participation which relate to the overall goals of the local health agency;

3. The maintenance and use of individual, family and other service records according to current professional standards;

4. Orientation in-service and continuing education programs for nursing staff;

5. Annual reports of services rendered which include pertinent statistics and descriptive narrative as related to objectives; and

6. Integration, in conjunction with the health educator, of the relevant components of the health promotion program into all activities involving public health nursing services.

**Note: At the request of the Public Health Council, the Department is reviewing N.J.A.C. 8:52-4.2 (d) 2 regarding the Certified Health Education Specialist (CHES) requirement for baccalaureate degree registered nurses. As a result, the Department will be issuing a recommendation to the Public Health Council and should any changes to the rule be required, it will appear in the New Jersey Register for public comment and final adoption. It is anticipated that the proposal will be developed by April 15, 2003 and that any revisions to the rule will occur in the next six months.**

**Until that time, local health departments that plan to hire new health educators should ensure that all candidates meet the requirements in N.J.A.C. 8:52-4.2 (d) 1 and 3 regarding acceptable degrees and experience. Local health departments should also ensure that candidates other than baccalaureate degree registered nurses meet the CHES requirement specified in N.J.A.C. 8:52-4.2 (d) 2.**